S. HRG. 98-920

ELDERLY CATASTROPHIC HEALTH CARE INSURANCE PROPOSALS

HEARING

BEFORE THE

SUBCOMMITTEE ON ECONOMIC GOALS AND INTERGOVERNMENTAL POLICY

OF THE

JOINT ECONOMIC COMMITTEE CONGRESS OF THE UNITED STATES

NINETY-EIGHTH CONGRESS

SECOND SESSION

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CONTENTS

WITNESSES AND STATEMENTS

THURSDAY, MARCH 29, 1984

	Page
Bentsen, Hon. Lloyd, vice chairman of the Subcommittee on Economic Goals and Intergovernmental Policy: Opening statement	1
Davis, Karen, chairman, Department of Health Policy and Management, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Md	4
Hutton, William R., executive director, National Council of Senior Citizens, Washington, D.C	22
Hacking, James, American Association of Retired Persons, Washington, D.C., accompanied by Jack Christy, AARP legislative representative	30
Merrill, Jeffrey C., director, Center for Health Policy Studies, Georgetown University, Washington, D.C	52
Shapland, Robert B., vice president and actuary, Mutual of Omaha Insurance Co., on behalf of the Health Insurance Association of America (HIAA)	69

SUBMISSIONS FOR THE RECORD

THURSDAY, MARCH 29, 1984

Bentsen, Hon. Lloyd: Letter to Hon. Margaret Heckler, Secretary of Health and Human Services, regarding catastrophic health care, dated March 27, 1984	3
Blue Cross and Blue Shield Association: Statement of	86
Davis, Karen: Prepared statement	9
Hacking, James, et al.: Prepared statement	33
Hutton, William R.: Prepared statement	25
Merrill, Jeffrey C.: Prepared statement	57
Shapland, Robert B.: Prepared statement	72

ELDERLY CATASTROPHIC HEALTH CARE INSURANCE PROPOSALS

THURSDAY, MARCH 29, 1984

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON ECONOMIC GOALS AND
INTERGOVERNMENTAL POLICY
OF THE JOINT ECONOMIC COMMITTEE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room SD-538, Dirksen Senate Office Building, Hon. Lloyd Bentsen (vice chairman of the subcommittee) presiding.

Present: Senator Bentsen.

Also present: George R. Tyler and Deborah Clay-Mendez, professional staff members.

OPENING STATEMENT OF SENATOR BENTSEN, VICE CHAIRMAN

Senator BENTSEN. The subcommittee will come to order.

I want to welcome you to this subcommittee hearing designed to explore the issue of catastrophic health-care insurance for the elderly.

Nearly 30 million older Americans have put a lifetime of effort into jobs, making homes, and raising families. And years ago, this Government made a decision to provide a system of retirement and health insurance to enable these and all Americans to retire in dignity. The system has become a model for other nations. Some provide greater benefits. Others provide fewer. But the basic government decision to ensure that Americans continue to enjoy a good quality of life upon retirement has never been questioned.

The key to this system is medicare. Perhaps the greatest threat to the emotional and financial well-being of older Americans is ill health. We are all too aware of the trauma facing the ill—the hopes and fears associated with the unknown and the pain of dealing with it day in and day out.

But an equally terrifying fear is the financial burden of health care. Medicare has failed in its promise to largely lift that fear from the shoulders of our elderly. It has failed for two reasons. First, the inevitable march of technology has opened up major new vistas in health care for the elderly. Opportunities to successfully deal with illness and extend life have soared—and with it the period that men and women receive quality medical care. In addition, inflation has pushed medical costs literally sky high. Medical costs are the fastest growing component of the CPI. They have

been for two decades, and we have been frustrated in trying to find ways to slow it down.

Both these factors mean that the elderly are living longer, receive more medical care, and have much larger medical bills than ever before. Yet, the medicare program does not reflect these new realities.

Presently, except for the first day of hospitalization, medicare will pay all covered hospital bills for only the first 60 days. For the next 30 days, the patients pay 25 percent of their bills. If an illness extends beyond 90 days, and 26,000 medicare beneficiaries experience that every year, the elderly must use up their 60-day lifetime allotment of reserve days, and pay one-half the bills out of pocket. After that reserve allotment is exhausted, they are on their own. Medicare closes its doors and turns its back.

Yet, for serious illness, the need for added care could well continue, as it does each year for thousands. In fact, nearly 200,000 elderly Americans each year have a spell of illness exceeding 60 days and become personally responsible for what could be limitless medical costs.

They may have so-called medigap private insurance to pay medicare deductibles and provide catastrophic coverage. But if not, they must literally become financially destitute before the only other Federal health care program—medicaid—will step in—all at a time when they are prey to the full range of emotional stress associated with prolonged illness.

It is indicative of the lack of attention to the catastrophic coverage gap that no one knows for certain how many Americans have exhausted or are currently exhausting their reserve days coverage. I am today sending a letter asking Secretary Heckler to provide me that information as quickly as possible.

The administration and its Advisory Council on Medicare Reform have proposed to close this catastrophic coverage gap as part of a broader recommendation designed to reduce the deficit. The proposal will raise elderly medicare costs by $700 million or more annually. We have received mixed reviews on that proposal. Yet it places the issue of catastrophic coverage under medicare squarely before this Congress.

The purpose of this hearing is to explore the adequacy of the present catastrophic coverage options that are available to the elderly. The focus is both on the hospital and physician parts of medicare.

We have a very distinguished group of witnesses here today, including Karen Davis, chairman of the Department of Health Policy and Management at Johns Hopkins University; Jeffrey Merrill, who is with the Health Policy Center at Georgetown University; William Hutton, who is with the National Council of Senior Citizens; Robert Shapland, who is vice president of Mutual of Omaha Insurance; and James Hacking, who is with the American Association of Retired Persons.

Ladies and gentlemen, I welcome you to this hearing.

I will include in the record at this point my March 27, 1984, letter to Secretary Heckler regarding catastrophic health care.

[The letter referred to follows:]

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Congress of the United States

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DAN LUNGREN, CALIF.
OLYMPIA J. SNOWE, MAINE

March 27, 1984

The Honorable Margaret Heckler
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Madam Secretary:

As you know, I am concerned with the inadequate protection for this Nation's elderly against catastrophic illness. Medicare provides full protection during each spell of illness for only the first 60 days. Beyond that period, medicare patients are exposed to open-ended medical bills without limit.

That prospect is a terrifying one when basic room charges today average an incredible $356 per person. A number of senior citizens subscribe to private insurance plans to cover catastrophic health care bills. But millions do not. They cannot afford such additional protection where premiums can exceed $40 per month. The result is a health care system out of balance. The sicker you are, the longer you are ill, the less protection you have under medicare.

Both Congress and the Administration are concerned with this catastrophic care gap. Proposals are sprouting left and right to close that gap through modifications to medicare. Yet, these proposals are being explored in a vacuum of little or no information. About four in every ten medicare subscribers will enter the hospital each year. Hundreds of thousands of them will stay longer than 60 days. And a good number will exhaust even the 30-day co-insurance period and their lifetime reserve days, as well. Could you please tell me:

1. The number of medicare subscribers in 1983 who stayed longer than 60 days in a hospital for one spell of illness and the amount of their medical bills not covered by medicare?

2. The number of medicare subscribers in 1983 who were forced to dip into some or all of their lifetime 60-day reserve under medicare, and their uncovered medical bills?

3. The number of medicare subscribers in 1983 who did not have private "medigap" insurance, and their uncovered medical bills?

4. The number of medicare subscribers in 1983 who exhausted their Reserve Days and the amount of their medical bills not covered by Medicare or "medigap" policies.

I hope you can supply this information to me promptly on a state-by-state basis. Thank you.

With best wishes,

Sincerely,

Lloyd M. Bentsen

Lloyd M. Bentsen
U. S. Senator

Senator BENTSEN. Ms. Davis, would you please start your presentation.

STATEMENT OF KAREN DAVIS, CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, SCHOOL OF HYGIENE AND PUBLIC HEALTH, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD.

Ms. DAVIS. Thank you, Mr. Vice Chairman. I have a somewhat longer prepared statement I would be happy to submit for the record.

Senator BENTSEN. It will be included in the record.

Ms. DAVIS. I do appreciate this opportunity to testify on the need for catastrophic coverage under medicare. Among the 30 million elderly and disabled medicare beneficiaries are those with limited financial resources, those with very serious disability conditions, and those for whom catastrophic medical expenses are commonplace. Even with medicare and medicaid, many aged persons face serious financial hardship and even forgo needed care because they cannot afford it.

Today, I would like to summarize information on the financial burden of health expenses on the elderly and I would like to conclude with some comments on steps that the Congress could take to alleviate the financial burden of high health costs on the elderly by adding catastrophic expense protection to medicare as part of a fundamental reform of the medicare program.

There are five major reasons for gaps in financial protection for the elderly even with medicare and medicaid.

The first of these reasons is that the medicare program contains deductibles and coinsurance provisions that require the elderly to pay a portion of covered benefits under medicare. This includes a hospital deductible which is currently $356 a year and a physician deductible which is currently $75 a year. In addition, the elderly are required to pay 20 percent of all allowable physical charges over the $75 deductible and if they are in the hospital for more than 60 days during a spell of illness, they also pay hospital coinsurance. So that is the first gap that leads to financial burdens on the elderly.

The second gap is the limit on covered hospital days under medicare. Currently 90 days are covered plus a 60-day lifetime reserve of hospital days. But once those days are exhausted, the elderly are liable for the full cost of hospital care. So that is another factor that affects 150,000 older Americans who have a very long hospital stay.

The third reason that the elderly frequently face catastrophic expenses is that physicians are not required to accept medicare fees as full payment for their services. This nonassignment of physician bills puts many elderly individuals in a situation where they must pay very large fees in excess of what medicare allows. An estimate for 1984 is that those physician fees in excess to allowable fees

total $3 billion. In other words, the elderly are paying $3 billion because physicians are not accepting assignment under medicare.

A fourth reason for the financial burden on the elderly is that the medicare benefit package excludes certain acute-care benefits. Prescription drugs is the most important of those excluded benefits, but also dental care, eyeglasses, hearing aids, and other essential services are not covered by the medicare program.

The final reason that I would cite why the elderly incur catastrophic expenses is that medicare has very inadequate long-term care coverage. Nursing home benefits are severely restricted, not only because there are limits on days but, more importantly, because the types of conditions for which medicare beneficiaries can qualify for long-term care assistance is quite limited.

So those are the five major reasons why the elderly, even with programs like medicare and medicaid, can find themselves facing very high medical costs—because there are cost-sharing requirements, the limit on hospital days, the nonassignment of physician fees, excluded acute-care benefits, and inadequate long-term-care benefits.

Together, in 1984, that meant that the elderly, even through private insurance or out-of-pocket payments, paid $1,700 per person privately for health-care expenses on top of amounts paid by medicare and other public programs.

Those gaps create serious financial burdens for three groups of elderly.

First, those elderly who are only covered by medicare. About 70 percent of the elderly purchase private health insurance to supplement medicare, so-called medigap insurance policies. Another 10 percent have coverage under medicaid as well as medicare. But that leaves about 20 percent of elderly beneficiaries who have medicare alone to help them pick up their health-care expenses.

In 1970, data from a national survey on national medical care, which excludes people in nursing homes—I am just talking about those outside of nursing homes—those individuals who are covered only by medicare paid about 11 percent of their income for health care out of pocket because of these various exclusions in medicare. Most of those individuals who have medicare only are near poor. There is an impression that medicaid picks up all the poor elderly, but half the elderly—I am talking about 13 million people—have incomes below twice the Federal poverty level. Of those, only 3.5 million elderly are covered by medicaid. So you are talking about almost 10 million near poor elderly who do not get medicaid and many of those simply have medicare without any supplementary private insurance. That is one group that is hard hit.

The second group that is hard hit are those that have very large medical expenses, and I am defining very large medical expenses as total medical bills in excess of $2,500 a year. Those elderly individuals who just have medicare coverage and have very high medi-

35-199 O—84——2

cal expenses spend over a third of their income out of pocket on health-care expenses. If they have both medicare and medicaid and they have very high medical expenses, they spend 9 percent of their income out of pocket. If they have medicare and private insurance but very large total medical bills, their out-of-pocket medical bills equal 18 percent of income. So the second group that is hard nit by these gaps are those that have very large medical expenses even if they also have protection from medicaid or private health insurance.

The final group that is hard hit, are those who require long-term care but we have fewer statistics on this group. Half of nursing home expenses in the United States are picked up by medicaid, but the other half are paid privately, nearly all of that out of pocket. There is very little private insurance protection for nursing homes or other long-term care benefits.

I would like to turn to a proposal that Congress might wish to consider for addressing these gaps that lead to catastrophic expenses and serious financial burdens on the elderly.

This proposal would entail fundamental reform of the medicare program and a redesign of the medicaid program to those beneficiaries covered by both medicare and medicaid.

It would involve the merger of part A of medicare and part B of medicare into a single program with integrated financing benefits and administration.

There would be a ceiling on out-of-pocket expenses that the elderly individual would be liable for. I am suggesting a ceiling of $1,500 per person on an annual basis for a combined part A-part B benefit package.

In addition, the limits on hospital days that now exist in the medicare program would be removed and the elderly could count toward that $1,500 maximum ceiling on out-of-pocket expenses any out-of-pocket expenses that they incur for prescription drugs. So it would not be a matter of adding prescription drugs to the medicare basic benefit package, but those expenses would count toward the maximum financial liability for a family.

In addition, there would be changes in the reimbursement provisions under medicare. In particular, physicians would be required to accept assignment of bills for services rendered to hospital inpatients. That would not involve the ambulatory side, but it would require assignment for physician services rendered to hospital inpatients.

Another component of this proposal would be a voluntary long-term-care insurance proposal so that the elderly could obtain coverage for nursing home care, day hospital, and selected other long-term-care benefits by voluntarily purchasing a long-term-care insurance package from the medicare program.

And finally, medicaid would be redesigned as an explicit wrap-around to the medicare program for low income medicare beneficiaries.

I think it is important that when we talk about improving protection for the elderly that we do so in a fiscally responsible manner. This proposal would be financed in the following way: The current payroll tax that is currently used to support the hospital portion of medicare would continue at the currently scheduled

rates. These payroll tax revenues would go into a new merged part A-part B medicare trust fund. There would be a single medicare trust fund, but the existing payroll tax revenues would flow into that fund.

In addition, the current general revenues that go to support part B of medicare would flow into this new merged trust fund for medicare, but the current part B premium would be eliminated and replaced by a new premium administered through the income tax system. That premium would be a minimum of $100 per elderly person but above that amount would be set at 2.5 percent of income of the elderly.

The current part B premium in 1985 averages about 2 percent of income. So I am proposing a slight increase in that premium to 2.5 percent of income, up an 0.5 percent increase over the current level, and there would be a maximum on that premium set at about half of the actuarial value of medicare.

So there would be a new premium not just for part B but for the entire medicare benefits package set at about 2.5 percent of income, but it would have a minimum so everyone would contribute and a maximum so that it would not be excessively high even for very high income elderly.

In addition, I am proposing that the cigarette tax revenues be doubled and earmarked for this medicare trust fund.

Senator BENTSEN. You are proposing what tax increase, please?

Ms. DAVIS. To double the cigarette tax and earmark those revenues for the medicare trust fund.

Senator BENTSEN. The Finance Committee just voted to let that tax go back down.

Ms. DAVIS. Yes, I understand.

Senator BENTSEN. I voted the other way, but I was very much in the minority.

Ms. DAVIS. This is assuming that that tax were to continue and that that would be doubled rather than eliminated.

I would like to move on to the financing for the long-term-care insurance proposal which as I indicated would be voluntary. The elderly would have the option of purchasing a long-term insurance benefit package under medicare. To do so, they would pay a premium set at 4 percent of income. This would also have a minimum premium of $200 a year. So all of the elderly who wanted these benefits would pay at least $200 a year or 4 percent of income, whichever was higher.

Those elderly wishing long-term-care insurance coverage could enroll as early as age 60 or as late as age 70, but benefits would not start until they had been enrolled for 5 years. So if they enrolled at age 60 and started paying the premium, they would become eligible for these long-term-care benefits starting at age 65. If they did not enroll until age 70, there would be a penalty for late enrollment of slightly higher premiums, but then again they would not receive benefits until age 75. So you must be enrolled for at least 5 years to obtain benefits.

Another part of this proposal is to try to achieve economies in the medicare program through changes in the methods of payments to providers and various incentives for efficiency in the medicare program. It would retain the current prospective hospital-pay-

ment system under medicare which limits increases in payments to hospitals to something called the hospital market basket plus 1 percent a year. That would be extended beyond its current expiration date out through 1995.

In addition, I am proposing that there be established a residual all-payers prospective-hospital-payment system in those States that do not have such a program.

I am also recommending a move toward prospective payment of physicians under medicare and, in particular, that physicians be required to accept medicare allowable fees for their services rendered to hospital inpatients. In other words, I am proposing mandatory assignment for services rendered to hospital inpatients. That provision would save the elderly roughly $1.5 to $1.7 billion a year in 1984 terms. So this would be a substantial savings to the elderly by having assignment of hospital physician bills while in the hospital and would offset any additional premium costs that they might face for acute-care benefits.

There are other provisions in the proposal that would try to avoid institutional care, whether that is hospital care or nursing home care. For example, the long-term benefit package would cover day hospital services and home health services to try to enable the elderly to live at home. There would be a preadmission review of the necessity for nursing home admission before that was done.

These ideas require careful consideration and debate as the Congress explores ways to assure the long-term adequacy and fiscal stability of the medicare program, but it would not be forgotten that medicare is essential to assuring that many of our Nation's most vulnerable citizens can live out their lives with dignity, free of the worry of financial ruin that major illness can bring.

Current fiscal problems in medicare should not cause us to lose sight of the major steps that need to be taken to improve, rather than dismantle, the medicare program.

Senator BENTSEN. Ms. Davis, we have something of a Pavlovian reaction to those buzzers and lights you are hearing and seeing on the wall in front of us. They are indicating that a vote has started on the floor, which means I must leave soon for 10 minutes. Could you summarize in the next minute or two?

Ms. DAVIS. I am finished, sir.

[The prepared statement of Ms. Davis follows:]

Prepared Statement of Karen Davis

CATASTROPHIC COVERAGE UNDER MEDICARE

Thank you for this opportunity to testify on the need for catastrophic coverage under Medicare. Among the 30 million elderly and disabled Medicare beneficiaries are those with limited financial resources, those with very serious disabling conditions, and those for whom catastrophic medical expenses are commonplace. Even with Medicare and Medicaid, many aged persons face serious financial hardship and even forego needed care because they can not afford it.

Today, I would like to summarize for the Committee information on health expenses of the elderly, and point out gaps in Medicare coverage that lead to excessive financial burdens on many elderly. I will conclude with some comments on steps that the Congress could take to alleviate the financial burden of high health costs on the elderly by adding catastrophic expense protection to Medicare as part of a fundamental reform of the Medicare program.

Health Expenditures of the Elderly

In 1981, the U.S. spent $83 billion on health services for the elderly, or 33 percent of all personal health care expenditures. The average expenditure for personal health

services for persons aged 65 and over was $3,140 in 1981, compared with $828 for those under age 65.

Expenditures for health care for the elderly are met from several sources. Contrary to common perception, Medicare covers less than half of the health expenses of the elderly. In 1981, Medicare paid 45.3 percent or $1,422 of the per capita bill for the elderly. Other sources of funding included Medicaid (13.7 percent or $430 of the per capita bill), other public programs (4.9 percent or $154) and private payments, including private health insurance and out-of-pocket expenses (36.1 percent or $1,130).

Gaps in Medicare coverage occur both because Medicare has substantial cost-sharing requirements for covered benefits, and because many health services are excluded from Medicare. The elderly are required to pay a deductible for the first day of hospital care ($356 in 1984), one-fourth of that amount for each day of care between the 60th and 90th day of hospital care in a given episode of illness, and one-half of that amount for each day of care in a 90 day lifetime reserve. Once these days of hospital care have been exhausted the elderly must pay all of their hospital expenses.

The elderly incur especially heavy costs for physician services. Medicare covers only half of the physician expenditures of the elderly. The elderly pay the first $75 of physician bills during the year, 20 percent of Medicare allowed physician fees above that deductible amount, and

the excess of all charges physicians make above the Medicare allowable fee. These charges can quickly become an enormous burden on the elderly.

The elderly also incur heavy financial burdens from services not covered by Medicare. Most nursing home care is not covered by Medicare. Medicare does not cover prescription drugs (except when a patient is hospitalized), dental care, hearing aids, eyeglasses, and many other health services essential to daily living.

Financial Burden of Health Costs on the Elderly

The financial burden of health care costs for the elderly is very unevenly distributed. Some elderly enjoy good health and rarely use health care services. Others are seriously disabled and require extensive treatment. Medicare and Medicaid assist many of those with serious health problems, but even with these programs many elderly, especially the near poor, can suffer financial hardship from health care bills.

Because the elderly are so different, health expenditures for this group are very skewed. In 1981, 79 percent of the elderly had annual Medicare reimbursements of less than $1,000, including 38 percent of the elderly who had no Medicare payments. At the other extreme are those elderly who require extensive care and treatment; 7.5 percent of the elderly

accounted for two-thirds of all Medicare payments, with an average payment of over $11,000 in 1981.

The elderly, for the most part, are not a prosperous group. Half of all families with an elderly member have incomes below twice the poverty level. (In 1981, the poverty level for an aged individual was $4,359; twice the poverty level was $8,718.) By contrast 30 percent of persons in families without an aged member have family incomes below twice the poverty level. In 1981, 15.3 percent of the aged had incomes below the poverty level, compared with 14 percent for all persons. For single, white, aged women, 28 percent had incomes below the poverty level, while 64 percent of single, black, aged women had incomes below the poverty level.

Medicare and Medicaid are extremely important to the elderly in meeting their health care bills. Together in 1981, these programs spent $49 billion on health care for the elderly. Almost 40 percent of Medicaid expenditures go for the care of 3.5 million elderly people.

Despite these programs, many elderly people already face serious financial burdens in meeting their health care expenses. In 1980, six percent of the elderly had out-of-pocket health care expenses (not counting health insurance premiums) exceeding $1,000, and 16 percent paid more than $500 directly for health care bills.

Out-of-pocket spending by the elderly is expected to

continue to grow. The Congressional Budget Office estimates that out-of-pocket costs for Medicare cost-sharing will be $505 per enrollee in 1984. The SMI premium, cost-sharing, and deductible will account for 80 percent of the cost. The SMI premium alone is now $162 per year. In addition, it is estimated that the average beneficiary will pay an additional $550 in 1984 for non-institutional care not covered by Medicare, most notably prescription drugs and dental care. If nursing home care were included, it would add another $650 per person, for a total out-of-pocket cost to the elderly of $1705.

Out-of-pocket medical expenses are a particular burden for those elderly who do not have supplementary coverage to Medicare -- either from Medicaid or private health insurance -- and for those with serious health problems. My colleagues at Johns Hopkins and I have recently analyzed data from the National Medical Care Expenditure Survey for 1977. We found that elderly households (excluding those elderly in nursing homes) who are covered only by Medicare spend 11 percent of their household incomes out-of-pocket on health care expenses, compared with 5 percent for those covered by both Medicare and Medicaid, and 8 percent for those with both Medicare and private health insurance.

The heavy financial burden on lower income elderly is in part a reflection of their inability to afford supplementary private health insurance to fill in the gaps left

35-199 O—84——3

by Medicare. Overall, 66 percent of the elderly have private health insurance in addition to Medicare. However, this varies widely by income. Of those poor or near poor elderly, 47 percent have private insurance compared with 78 percent of the high-income elderly.

Even those with supplementary coverage can experience quite burdensome medical expenses if they are seriously ill. For elderly of all incomes with health care bills exceeding $2,500 in 1977, those with Medicare alone spent 37 percent of their income on health care, those with both Medicare and Medicaid spent 9 percent of their income on health care, and those with Medicare and private insurance spent 18 percent of their income on health bills. For the poor and near-poor elderly households with total health care bills exceeding $2,500 in 1977, those with Medicare alone spent 53 percent of their incomes out-of-pocket on health care expenses, those with Medicare and Medicaid spent 10 percent of their incomes, and those with both Medicare and private health insurance spent 30 percent of their incomes on out-of-pocket expenses. These figures are based on those living at home; the financial burden of nursing home care for those elderly not eligible for Medicaid can pose even greater hardships.

Heavy financial burdens for those with catastrophic medical expenses can occur even for those elderly purchasing private health insurance to supplement Medicare. Few "Medi-Gap"

policies pick up physician charges in excess of Medicare's allowable fees. In addition, such supplementary policies can be extremely expensive, and return few benefits in exchange for high premiums.

Catastrophic Coverage under Medicare

The growing inadequacy of protection afforded by Medicare coupled with very real fiscal problems in the program call for an imaginative and far-reaching reform of current approaches to financing health care for the elderly. Reform of the financing of acute and long term care services for the elderly should address several problems inherent in the current system. These include the financial burdens the elderly incur because of serious gaps in coverage and limitations on benefits, the projected deficit in the Medicare Hospital Insurance Trust Fund, the general problem of rapidly increasing expenditures for both hospital and physician services for the elderly, and fragmented and inadequate coverage of long term care.

Reform of Medicare to remedy these problems should be designed in a fiscally responsible manner. This involves rethinking the entire structure of the program, including current eligibility provisions, benefits, financing sources, provider payment methods, administration, and the need for innovative features to reform delivery of services.

The basic strategy would be to merge Part A and Part B of Medicare into a single plan with a ceiling on out-of-pocket expenses, develop a new voluntary long term care plan under Medicare, and design a separate Medicaid program for Medicare beneficiaries that would provide wrap-around protection for low-income elderly. The principal features of this plan include:

o Coverage. The new Medicare program would cover all persons aged 65 and over (not just those covered by social security) and the disabled qualifying under current eligibility provisions. The new Medicaid wrap-around coverage would be extended to all poor elderly with a spend-down provision for the near poor.

o Benefits. Part A and Part B Medicare benefits would continue in the new Medicare plan, with the removal of limits on covered hospital days. Deductible and coinsurance provisions for hospital and physician services would be continued. However, a new ceiling on out-of-pocket expenses of the elderly would be incorporated set initially at $1500 and indexed over time with the growth in program expenditures. Expenses counting toward this maximum ceiling include all out-of-pocket expenditures for hospital, physician, and other Medicare benefits, plus prescription drug costs. Once an elderly individual had paid $1500 in a given year for these health expenses, Medicare would pay all additional incurred costs for covered benefits and prescription drugs.

The optional voluntary long term care plan under Medicare would cover nursing home care (in qualified skilled nursing facilities and intermediate care facilities), home health services (in addition to more limited home health benefits available in the acute care Medicare plan), and day hospital services. These services would be subject to a 10 percent coinsurance charge, and a maximum ceiling on out-of-pocket costs of $3,000 annually. Elderly wishing to obtain long term care coverage could enroll beginning at age 60, but benefits would not be initiated until enrolled at least five years in the plan. No one would be permitted to enroll after age 70. This plan would be supplemented with a direct grant program to public and non-profit community organizations to provide home help services such as chore services and personal care services to the functionally impaired.

The Medicaid wrap-around plan would pay the cost-sharing required under the acute care part of Medicare for all elderly with incomes below the federal poverty level. A spend-down provision would assist those elderly who otherwise would have their incomes net of out-of-pocket expenses reduced to below poverty. The current Medicaid coverage of long term care services would continue as a safety net for those poor elderly unable or declining to obtain long term care coverage available on a voluntary basis under Medicare.

o Financing. Part A and Part B Medicare trust funds would be merged into a single trust fund. The current Part

A payroll tax would be retained as a source of revenue to the new trust fund, continued at its current legislated rate. General revenues currently projected to support Part B of Medicare would be added to the fund. The current Part B premium would be replaced with an income-related premium. This new Medicare premium would be set at 2.5 percent of taxable income of Medicare beneficiaries (compared with a current premium projected to be $203 in 1985, or approximately 2.0 percent of income). The premium would be administered through the personal income tax system. The definition of income would be broadened, to be consistent with provisions in the Social Security program for taxing social security benefits of higher income elderly. The new premium would be capped at $1,000 annually, so that no beneficiary would be required to pay a premium exceeding 50 percent of the actuarial value of Medicare. A minimum annual premium of $100 would assure that all elderly make some contribution; for those not required to pay income taxes, this minimum premium could be paid directly to the Medicare program. Both the minimum and maximum premium rates would be indexed over time with increases in program expenditures.

Additional revenues for the Medicare trust fund would be contributed by doubling the current tax on cigarettes. These funds would be earmarked for Medicare, and added to the trust fund.

Optional long term care coverage would be available

with the payment of an income-related premium set at 4.0 percent of income for those elderly enrolling at age 60, with a minimum annual premium of $200. The premium would be increased for those postponing enrollment. No one could enroll beyond age 70. Benefits could not be initiated until covered at least five years under the plan. Federal general revenues would be used to meet any long term care expenditures not covered by the premium. Categorical federal grant funds would be used to establish home help service programs through public or non-profit community organizations.

The federal government would assume 100 percent of the cost of Medicaid supplementation of Medicare acute care cost-sharing. However, federal support to states for residual Medicaid long term care coverage for Medicare beneficiaries would be reduced by half the current contribution rate. For beneficiaries receiving long term care through Medicaid, rather than the voluntary long term care plan, Medicaid would assume the full cost--not just the coinsurance provisions in Medicare.

o Provider Payment. Improved benefits and expanded financing of acute and long term care services would be coupled with stringent cost containment measures. The current prospective payment system for hospitals under Medicare would be retained and strengthened. A residual all payer hospital prospective payment system covering privately insured patients as well as Medicare and Medicaid beneficiaries

would be adopted for those states that do not voluntarily adopt such systems. A prospective physician payment system would be established, and physicians would be required to accept Medicare prospective payment rates for services rendered to hospital patients. A prospective payment system for nursing homes would be also be established, taking into account the level of complexity involved in the care of patients with different functional impairments. Payment on a capitation basis would be encouraged for health maintenance organizations. Demonstrations to test capitation payment for nursing home patients, covering both acute and long term care would be instituted as a basis for evolving a longer term prospective payment system based on capitation.

o <u>System Reform</u>. Appropriate care patterns would be encouraged through assessment of patient condition, and making long term care benefits contingent upon necessity as determined by qualified physicians. Profiles of practice patterns would be established for all benefits, and utilization review instituted for all claims falling outside accepted practice pattern norms. Emphasis would be placed upon avoiding institutional care -- either in hospitals or nursing homes -- where possible. Pre-admission assessment would be required for admission to nursing homes. Day hospital services would be covered under the voluntary long term care plan as an alternative to institutional care. Respite care would be provided so that family members supporting a functionally

impaired elderly at home could have periodic breaks. Grants to public or non-profit organizations to provide home help services -- such as chore services and personal care services -- would be provided to enable more functionally impaired elderly to remain in their homes. These home help services would also be based upon level of dependency, and need for such assistance. Volunteer workers in home help agencies could earn credits to be applied toward their own voluntary long term care premiums.

These ideas require careful consideration and debate as the Congress explores ways to assure the long-term adequacy and fiscal stability of the Medicare program. But it should not be forgotten that Medicare is essential to assuring that many of our nation's most vulnerable citizens can live out their lives with dignity, freed of the worry of financial ruin that major illness can bring. Current fiscal problems should not cause us to lose sight of the major steps that need to be taken to improve, rather than dismantle, the Medicare program.

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Senator BENTSEN. Thank you very much, Ms. Davis, your proposal is quite a sweeping one. I certainly think you are correct in focusing on out-of-pocket costs and trying to get some action on reining them in.

I am concerned that your proposal is too sweeping for the administration to digest at one fell swoop. You are suggesting that some limitations be placed on the out-of-pocket costs, which I understand now average about $1,700 per year for hospitalized medicare patients.

What kind of a stopgap or near-term step could be taken quickly to place a lid on out-of-pockets cost If you could not implement your entire package now, where would you start? What would you do?

Ms. DAVIS. I think that the two things that would be most important would be this assignment of physician bills rendered for hospital inpatients. Nonassignment costs the elderly about $3 billion and I would put that up as a very high priority.

The second thing that I think should be done is impose some kind of ceiling. I have recommended $1,500 as the maximum financial out-of-pocket liability of the elderly. One might pick a different number, higher or lower, but I would focus on those two things as the most essential to provide some immediate relief to the elderly for burdensome out-of-pocket bills.

Senator BENTSEN. On your proposal for combining part A and part B, how do you respond to critics like Wilbur Cohen who say part A benefits are entitlements—that they are already paid for with payroll taxes?

Ms. DAVIS. I do believe that the medicare program is an entitlement. The payroll taxing would continue. Under this proposal, everyone would automatically be covered. It is not a means-tested proposal where only low-income elderly would be covered. I do view this as an entitlement program and I think it is important that all of the elderly be covered by this proposal.

In my own view, I would not vary the benefits of medicare with the person's income either. However, I think on the taxing side, the payroll tax varies with income; the income tax varies with income; and we could have a premium going to support the program that would vary with income and that would not violate the social-insurance-entitlement nature of the program.

Senator BENTSEN. I am going to have to go vote, now. Ms. Davis, I understand you have a tight schedule. Let me thank you now very much for appearing. It will take me about 10 minutes round trip, so we will take a short recess and reconvene at that time.
take a short recess and reconvene at that time.

[A short recess was taken.]

Senator BENTSEN. Ladies and gentlemen, thank you very much for your patience. We will get underway again.

Mr. Hutton, will you proceed with your testimony.

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, D.C.

Mr. HUTTON. Yes, sir. I would like to submit my prepared statement for the record and perhaps just hit a few highlights.

Senator BENTSEN. It will be included in the record.

Mr. HUTTON. I want to thank you. My name is Bill Hutton and I am the executive director for about 22 years for the National Council of Senior Citizens, and I thank you for this opportunity to discuss the issue of catastrophic health insurance.

We support the concept of catastrophic health insurance as a means to protect the elderly from devastating medical expenditures, but I would like to say here and now that I think the word "catastrophic" needs to be clarified and defined since it means so many things to so many different people. When you mention catastrophic health insurance, most people would probably think coverage for an episode of acute illness or injury which requires lengthy hospitalization and expensive treatment. While this would be the case for younger people, though by no means their only catastrophic expense, it is not the norm for older people.

In fact, for the majority of older people we find there is a need for catastrophic coverage not to insure against the cost of a hospital stay of unusual length, but the cost of the more chronic illnesses requiring long-term care. Alzheimer's disease or stroke victims, for example, are cases which could incur catastrophic expenses not currently covered by insurance.

Several catastrophic insurance proposals are being discussed in the Congress, but few would meet the elderly's true catastrophic insurance needs. An example is the administration's catastrophic tradeoff. It would help merely 0.6 percent of medicare beneficiaries, but it would increase costs for every beneficiary hospitalized less than 60 days. Other plans proposed to the Congress would require high levels of out-of-pocket spending before catastrophic coverage begins.

Now I was interested in Dr. Davis' testimony this morning in which she reported the Congressional Budget Office estimates that out-of-pocket costs for medicare costsharing, if they include nursing home care, in 1984 will be a total out-of-pocket cost for the elderly of $1,705. When you think of rent, and then you think of clothing, and you think of high staggering cost of energy, and then you think of the prices of all the other things which are going up, all the millions and millions of older people are not going to be able to afford that kind of cost. So it is going to be catastrophic for them all right just to meet what is coming up in the normal course of events, but if they have a very serious illness on top of that, God help them.

The thing that worries us, Senator Bentsen—and I know that you are a serious-minded man who really wants to help older people and our experience of you is also that you have the skills to be able to make a great contribution in this area and we wish you well.

Senator BENTSEN. Thank you.

Mr. HUTTON. But there is something that we need before that. We need a health-care system in which costs are under control. We need to be sure that medicare's solvency is secure whether or not there is catastrophic insurance in place.

The National Council of Senior Citizens believes that many older people would benefit from the right kind of catastrophic coverage. However, all medicare beneficiaries could face problems of catastrophic proportions if medicare goes bankrupt. They would all face

catastrophic expenses if Congress enacts short-term-financing plans such as those proposed by the administration and the Advisory Council on Social Security. These plans merely shift the Federal Government's cost to the elderly.

We believe that Congress must place high priority on assuring medicare's solvency by controlling costs in the larger health-care system. Legislation must be directed at the causes of rising costs, not simply shift those costs onto the people who need medical care. This is the only fair and effective way to solve the problems produced by more than a decade of excessive health-care price increases.

We support the Medicare Solvency and Health Care Cost Control Act of 1984, S. 2424, and H.R. 4870, which have been introduced by Senator Edward Kennedy and Representative Richard Gephardt. We believe it would effectively control health-care costs for the next 20 years without raising taxes or cutting medicare and medicaid benefits.

I did like the concept, however, advanced by Dr. Karen Davis this morning that at least a start could be made on physicians' in-hospital services by having them accept assignment. I would like doctors everywhere to accept assignment for medicare, but we could make a start and save older people $3 billion right there.

Anyway, the Kennedy-Gephardt plan we think would be very useful. I am not saying we should not have catastrophic insurance. I think there is a need for the right one, but for God's sake, let us control costs because that would even ruin a good catastrophic insurance plan. At least the Kennedy-Gephardt plan would slow the rate of increasing costs for hospital services and physicians' in hospital care. Between 1985 and 2005, it is estimated it would render the medicare hospital insurance trust fund solvent and give the program a net surplus of $29 billion by 2005. Now that is the kind of news that older people are looking for. They are worried, Senator Bentsen. They are worried about the fact that it looks bad for medicare. Things look terribly bad for medicare and they know that they cannot afford to pay. They know that they cannot afford to pay these staggering high costs and nobody seems to be doing anything to control these costs. We believe that the Congress should support this kind of legislation.

That is all I would like to say for now, Mr. Chairman.

[The prepared statement of Mr. Hutton follows:]

PREPARED STATEMENT OF WILLIAM R. HUTTON

CATASTROPHIC HEALTH COVERAGE FOR THE ELDERLY

Mr. Chairman, thank you for the opportunity to speak to you today on behalf of the more than 4.5 million older people the National Council of Senior Citizens represents nationwide. NCSC is a non-profit non-partisan membership organization founded during the battle to enact Medicare. Today the health of the elderly and the adequacy of their health insurance coverage are two of our primary concerns.

We support the concept of catastrophic health insurance as a means to protect the elderly from devastating medical expenditures. The elderly incur medical expenses three times greater than do people under age sixty-five. Yet Medicare pays only 44 percent of these expenses; 30 percent is paid out-of-pocket. Therefore, catastrophic coverage has special significance for older people.

However, "catastrophic" coverage needs to be clarified and defined since it means many things to many people. When you mention catastrophic health insurance, most people would probably think of coverage for an episode of acute illness or injury which

requires lengthy hospitalization and expensive treatment. While this would be the case for younger people, though by no means their only catastrophic expense, it is not the norm for older people.

Only two tenths of one percent of Medicare beneficiaries are hospitalized longer than 60 days. The average stay is 11 days. Medicare pays 100 percent of the costs between the second and sixtieth day. After this period, the cost of daily hospital co-payments under current law could indeed be catastrophic. For the majority of older people, however, the need for catastrophic coverage is not to insure against the cost of a hospital stay of unusual length, but the cost of the more chronic illnesses requiring long-term care. Alzheimers disease or stroke victims, for example, are cases which could incur catastrophic expenses not currently covered by insurance.

Several catastrophic proposals are being discussed in the Congress, but few would meet the elderly's true catastrophic insurance needs. An example is the Administration's catastrophic trade-off. It would help merely .2 percent of Medicare beneficiaries, but it would increase costs for every beneficiary hospitalized less than 60 days. Other plans proposed to the Congress would impose heavy costs on the elderly. These plans, for example, would require high levels of out-of-pocket spending before catastrophic coverage begins. Some plans show considerable promise, but, regrettably, none has been introduced in the Congress. These plans would implement catastrophic coverage, not as a piecemeal, patch-up approach, but as a part of overall health system reform to benefit people of all ages.

We must be very cautious about catastrophic coverage. Too many proposals lately have been labeled "catastrophic" when in fact they would increase beneficiary costs. Therefore, the National Council of Senior Citizens examines proposals carefully and with moderate skepticism. To illustrate, let me ask the questions we believe we all should ask about a catastrophic insurance plan:

What is a catastrophic expense?

- It could be the Part A deductible of $356 for a senior citizen with recurring illness that requires multiple hospital stays, each in a new benefit period.

- It could be a $50 prescription drug bill for a widow whose sole income is Social Security but who is over-income for Medicaid.

- It could be the cost of a year-long stay in a nursing home for a middle income retired man.

What is meant by catastrophic coverage?

- Is it the elimination of Part A co-payments without a "compensating" early hospitalization daily co-payment?

- Is it a trade-off between a new daily co-payment on short hospital stays and the current Part A co-payment after 60 days?

- Will it pay for only certain "allowable" expenses, for example, current Medicare reimbursable costs?

- Does it require the beneficiary first to reach a trigger level of out-of-pocket medical expenses, or perhaps spend a certain proportion of adjusted gross income?

- Will it expand Medicare benefits or continue to exclude such items as prescription drugs, mental health services, and nursing home stays?

- Will it reform reimbursement methods?

- Will it first raise Medicaid benefits to the Medicare level, federalize the program, or otherwise make the program nationally uniform?

How would catastrophic coverage be financed?

- Would it be funded as the Administration suggests by co-payments from the less acutely ill elderly?
- Would it be an additional insurance policy offered by private insurors to supplement the current faulty system?
- Would it raise taxes to fund the program and retain the current delivery and payment mechanisms of Medicare?

Why is it being discussed?

- Are we trying to achieve reform or just adding another layer to our current system?
- Perhaps it is because our current system is getting so expensive that a new insurance plan would be created to help people whose medical expenses are so high that they cannot pay their bills.

These are not trivial questions. NCSC believes they must be answered. We also believe that any catastrophic health insurance proposal should be scrutinized very carefully. But perhaps the most important question to ask is this one:

What do we need before catastrophic health care insurance?

We need a health care system in which costs are under control. We need to be sure that Medicare's solvency is secured--whether or not there is catastrophic insurance in place.

The National Council of Senior Citizens believes that many older people would benefit from the right kind of catastrophic coverage. However, all Medicare beneficiaries could face problems of catastrophic proportions if Medicare goes bankrupt. They all could face catastrophic expenses if Congress enacts short-term "financing" plans such as those posed by the Administration and the Advisory Council on Social Security. These plans merely shift the Federal government's costs to the elderly.

We believe that the Congress must place high priority on assuring Medicare's solvency by controlling costs in the larger health care system. Legislation must be directed at the causes of rising costs, and not simply shift those costs onto the people who need medical care. This is the only fair and effective way to solve the problems produced by more than a decade of excessive health care price increases.

The National Council of Senior Citizens supports the Medicare Solvency and Health Care Cost Control Act of 1984, S. 2424 and H.R. 4870. The bill was introduced by Senator Edward M. Kennedy and Representative Richard A. Gephardt. It would effectively control health care costs for the next twenty years without raising taxes or cutting Medicare and Medicaid benefits. It is a welcome and promising alternative to three years of budget reductions which have not altered the inflationary spiral in medical prices. This policy has imposed heavy burdens on the elderly, the poor, workers and many children.

The Kennedy/Gephardt legislation would save billions of public and private health care dollars. It calls for a system-wide approach based on a combination of regulatory and competitive elements and state cost-control programs. The plan would slow the rate of increase in costs for hospital services and physicians' in-hospital care. Between 1985 and 2005, it would render the Medicare Hospital Insurance Trust Fund solvent and give the program a net surplus of $29 billion by 2005. Private sector savings are projected to be $2.4 trillion by 2005.

We urge you to support this legislation. It is an important step toward controlling increases in the cost of medical care already catastrophic to millions of people. It will also benefit a far greater constituency than the elderly. After all, the cost of our health care system is a problem for Federal, state, and local governments' budgets, for workers and their employers, for low-income people and persons with inadequate insurance coverage, as well as for the 30 million elderly and disabled persons who are Medicare beneficiaries. We urge you and your Congressional colleagues to approach the problem with long-term solutions that can be enacted today.

Senator BENTSEN. You said a lot, Mr. Hutton. You are an articulate spokesman.

I think what I will do here is ask each of you to summarize your statements and then I will ask each of you questions at once to receive your contributions that way too. The reason I choose such a procedure is that we are going to have some more votes on the floor.

Mr. Hacking, please proceed.

STATEMENT OF JAMES HACKING, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, D.C., ACCOMPANIED BY JACK CHRISTY, AARP LEGISLATIVE REPRESENTATIVE

Mr. HACKING. Thank you, Mr. Chairman. On my right and accompanying me is Jack Christy, who is one of the AARP legislative representatives.

We are here representing the American Association of Retired Persons which currently has a membership of approximately 16 million persons age 50 and older. With the association's statement included in the record of the hearing I shall try to keep my remarks to the minimum.

Senator BENTSEN. We will include your prepared statement in its entirety.

Mr. HACKING. Thank you.

Per capita health-care spending for the elderly in fiscal year 1981 was $3,140. That was more than 3½ times the per capita spending for persons under age 65.

Since medicare pays for less than half of the elderly's health-care expenses—roughly 45 percent—the elderly are painfully aware of the cost of paying for their own health-care needs out of pocket.

By the end of 1984, this annual health expenditure will have risen to $1,550, an amount representing 15 percent of elderly income. Thus, the elderly are now spending as much of their income for health care as they did prior to the implementation of medicare in the mid-1960's. Furthermore, assuming that there are not further cutbacks in medicare program, almost 20 percent of

elderly per capita income will be consumed by health-care expenditures by the year 2000.

Personal liability for the cost of health care provided to the elderly derives from a number of sources, all of which have been subject to significant increases over the past several years. These costs include the deductibles under parts A and B of medicare, coinsurance, charge reductions associated with unassigned physician claims, the cost of nonmedicare-covered services, much of the cost of nursing home care, the medicare part B premium, and the premium for private medicare supplementary or so-called medigap insurance.

Catastrophic health insurance coverage is usually discussed in the context of an acute-care crisis, precipitated by a prolonged hospital stay. AARP believes that length of stay alone should not be the sole criterion for defining the catastrophic health care occurrence. We think out-of-pocket expenditures must also be considered.

Recently, three catastrophic health insurance proposals have been receiving serious attention. The first, of course, is that of the administration which would require beneficiary coinsurance for days 2 through 60 of a hospital stay with catastrophic protection coming into play after day 60.

The problem with this proposal is that while somewhat less than 2 percent of medicare part A users would benefit, about 98 percent of part A users would pay more than they currently do. Moreover, each beneficiary who reaches the 61st day of hospitalization and thus would become eligible for the catastrophic protection would have already paid about $1,500 out-of-pocket compared with only $356 under current law.

The second proposal is the Catastrophic Expense Protection Act, S. 2163, which is sponsored by Senator Durenberger. Like the administration proposal, S. 2163, despite its $2,500 expenditure cap, would increase out-of-pocket costs associated with hospital and physician care for most beneficiaries, while benefiting relatively few.

Under current law the part A deductible is scheduled to be $404 in 1985. Even though S. 2163 would roll back this deductible to $350 in that year, beneficiary cost sharing for an average hospital stay under this proposal would still be 44 percent higher in 1985 than under current law. To pay less under this particular proposal than under current law, an aged beneficiary would have to remain hospitalized for at least 75 days. Since less than 1 percent of medicare enrollees have continuous stays of more than 74 days, 99 percent of the beneficiaries would end up paying more.

The final model proposal is one developed by the Health Care Financing Administration. Like S. 2163, this proposal would limit the amount of medicare A and B cost-sharing liability to which any aged enrollee would be subject. Unlike S. 2163, however, the HCFA proposal accomplishes its catastrophic cap through the imposition of an annual surcharge on all medicare beneficiaries. HCFA has projected that in 1984 a cap of $400 would require a surcharge of $161 for combined part A and part B liability.

The HCFA proposal has some distinct advantages. It would distribute medicare cost-sharing liability among all enrollees, rather than restricting it merely to the sick or injured. It would set maxi-

mum, predictable limits on deductible and coinsurance expenditures that are more realistic than the limit proposed in S. 2163. The limit there, as I said, is $2,500. It also could substantially reduce the need for the purchase of certain medigap policies by the elderly. Finally, it would offer some peace of mind to the elderly individuals concerned about substantial deductible and coinsurance expenditures associated with parts A and B of medicare.

The HCFA proposal, nevertheless, does have some limitations. For one thing, the proposal does not incorporate protection against the cost of non-medicare-covered goods and services or charges above what medicare allows for physician services. Also, depending upon the level at which the surcharge is set, the surcharge itself could represent a very significant financial burden, especially for the poor and near-poor elderly.

The AARP believes there is a demonstrable need for catastrophic health insurance coverage for the elderly, and this is most pronounced in the area of long-term care and the costs associated with that.

At this point, however, the association urges great caution in incorporating what may turn out to be expensive new commitments into medicare when the program is headed rapidly toward insolvency and the Federal Government faces huge economic-recovery-threatening budget deficits. AARP believes that the most urgent, indeed catastrophic, need for medicare is to put that program on a viable financial footing. The association accordingly recommends across-the-board limits on increases in payments to hospitals and physicians. Not only will a substantial reduction in the rate of increase in hospital costs and physician fees improve medicare's financial picture, but it would also improve the overall Federal budget deficit picture and, in addition, slow down the very rapid rate of increase in the elderly's out-of-pocket costs.

That concludes my remarks, Mr. Vice Chairman. Thank you.

[The prepared statement of Mr. Hacking follows:]

PREPARED STATEMENT OF JAMES HACKING

The American Association of Retired Persons (AARP) appreciates this opportunity to present its views on catastrophic health care insurance for the elderly before the Joint Economic Committee. The Association recognizes that the elderly have a vital interest in securing protection against the costs of catastrophic illness. While the elderly have a far higher incidence of illness -- especially chronic and long-term illness -- than any other population group, they are the least able to afford the high costs associated with such illness. Per capita health care spending for the elderly in fiscal year 1981 was $3,140, more than 3½ times that for persons under the age of 65. These statistics, when juxtaposed with income statistics which show that the median income level of elderly headed households is one-half that of households headed by a person under 65, demonstrate just how vulnerable the aged are to high medical costs.

Introduction

The elderly are the most cost conscious health care consumers in this country. They have to be. Although they represent less than 12 percent of the population, the elderly account for 31 percent of all expenditures for hospital services, 28 percent of expenditures for physician services, 24 percent of prescription drug expenditures and 80 percent of all nursing home expenditures. Since Medicare pays for less than half of the elderly's health care expenses (about 45 percent), the elderly are painfully aware of the cost of paying for their own health

care needs out-of-pocket. The escalating cost of Medicare and corresponding increases in beneficiary liability are a function of uncontrolled health sector inflation, particularly hospital cost inflation and physician fee inflation.

Beneficiary Out-of-Pocket Costs

In 1977, the elderly spent approximately $698 or 12% of their mean per capita income to cover, out-of-pocket, the cost of medical goods and services. By the end of 1984, this annual health expenditure will have risen to $1550, an amount representing 15% of elderly income. Thus, the elderly are now spending as much of their income for health care as they did prior to the implementation of Medicare. Further, assuming that no further cutbacks in Medicare are enacted, almost 20% of elderly per capita income will be consumed by health care expenditures by the year 2000.

Personal liability for the cost of health care provided to the elderly derives from a number of sources, all of which have been subject to significant increases over the past several years. The elderly pay directly for the following:

1. Deductibles under Parts A & B:

   The Part A deductible has increased from $104.00 in 1975 to $356.00 in 1984, an increase of 242 percent over the past 8 years. The annual Part B deductible has increased from $60.00 in 1980 to $75.00 in 1983 (an increase of 25 percent).

2. Coinsurance (Part B) :

Actual per capita coinsurance charges borne personally by the elderly increased by 345 percent between 1972 and 1982.

3. Cost-sharing (Parts A and B) :

In 1981, out-of-pocket payments for both the inpatient deductible and coinsurance liability constituted over 14 percent ($5.3 billion) of all hospital expenditures, a 23 percent increase in out-of-pocket payments since 1977.

4. Charge reductions on unassigned claims (i.e., the difference between the Medicare "allowed" charge and the actual charge by the physician for which the beneficiary is personally liable):

Between 1977 and 1982, the total dollar amount of "charge reductions" passed on to elderly Medicare beneficiaries jumped from $674,000,000 to $2,006,000,000 (an increase of 198 percent over a five-year period).

Approximately 46 percent of all Part B claims submitted to Medicare for reimbursement at this time are "unassigned," compared to an over-50 percent non-assignment rate in 1977. Nevertheless, beneficiary liability for "unassigned" claims has increased dramatically over the past five years even though the number of claims paid on assignment has increased during the same period.

5. Non-covered services:

Aged Medicare beneficiaries are personally liable for a significant number of critical non-covered services and products -- including dental services, dentures, prescription drugs, eye glasses, hearing aids, etc. -- for which they paid about $7 billion out-of-pocket in 1981, a 60 percent increase in their out-of-pocket liability for such products and services since 1978.

6. Coinsurance for Skilled Nursing Home Care and charges for all ICF care:

Approximately half of all nursing home expenditures made on behalf of the aged were financed directly by out-of pocket payments in 1981. As HCFA researchers have noted: "Even if other sources comprised half of the total payments, the average out-of-pocket expenditure for private-paying patients would still be over $100 per week."

7. SMI (Part B) Premiums:

Out-of-pocket premium payments by the elderly for Medicare Part B coverage totalled $78 annually in 1977 as compared with a current annual figure of $175.20, a 125 percent increase in SMI premium payments by the elderly over the past seven years.

8. Private Health Insurance Premiums:

Approximately 67 percent of aged Medicare beneficiaries are sufficiently concerned about the gaps in Medicare

coverage to purchase private health insurance policies designed to supplement medical expenses. Currently, low option private insurance plans cost aged Medicare beneficiaries approximately $230 per year, while high option plans can exceed $700 per year. These figures compare with an annual private insurance premium rate of $90 just five years ago.

Out-of-Pocket Costs Associated With Part B Only

Under existing law, Medicare beneficiaries have substantial responsibility for the cost of physician services. Beneficiaries must pay the annual Part B deductible of $75, plus 20 percent coinsurance on all reasonable, customary, and prevailing physicians' charges. Between 1972-1982, incurred coinsurance charges increased by approximately 345 percent. Moreover, beneficiaries are liable for all charge reductions associated with unassigned physicians' claims. In 1980, aged beneficiary liability resulting from unassigned claims exceeded $1.3 billion, an amount representing 13 percent of total physicians' charges for the elderly that year. By 1982, unassigned claim liability had risen to $2 billion.

Beneficiary liability for physicians' services results, of course, not only from unassigned claims, but also from deductible and coinsurance charges. These three charge components--charge reductions associated with unassigned claims, deductible, and coinsurance--together represent "variable beneficiary liability" for physicians' services. In 1980, such variable

liability for the aged amounted to nearly 35 percent of total physicians' charges due. Further, if Part B premium payments representing a form of "fixed beneficiary liability" are combined with "variable beneficiary liability" for 1980, the net Medicare contribution against total physicians' charges falls to only 45 percent, the aged beneficiary being responsible for the remaining 55 percent of charges due the physician. It is estimated that total beneficiary liability for physicians' charges due under Medicare have increased to over 60 percent in 1983.

The statistics which have been cited above are based on aggregate data and averages; accordingly, they tend to obscure the personal catastrophe suffered by those elderly individuals who experience unusually high out-of-pocket medical costs, i.e., those costs resulting from a catastrophic illness, injury, or condition. A catastrophic episode can occur in conjunction with an acute medical crisis or with the need for costly long-term care.

The Acute Care Crisis

Catastrophic health insurance coverage is usually discussed in the context of an acute care crisis, precipitated by a prolonged hospital stay. Though length of stay does have a strong correlation to the gravity of an acute care occurrence, and thus to its cost, AARP believes that length of stay alone should not be the sole criterion for defining a catastrophic health care occurrence. Out-of-pocket expenditures, either because of the catastrophic occurrence, a long rehabilitation or necessary health maintenance services, must be considered in developing an adequate catastrophic protection plan. Unfortunately, there are not any catastrophic health insurance proposals that provide the requisite flexibility to meet such varying needs.

Recently, three acute care, catastrophic health insurance proposals have been under serious consideration. The first is the Administration's FY 1984 budget proposal requiring Part A users to pay, in addition to the deductible, 8% of the deductible ($28) for the 2nd through the 15th day of hospitalization and 5% ($17.50) for the 16th through the 60th day of hospitalization for any spell of illness, with catastrophic protection for Part A services triggered only after the 60th day.

For an average Medicare hospital stay of 11 days, beneficiaries would pay an additional $280 (plus a $46 increase in the Part A deductible effective January 1, 1984), equaling a 107% increase in the average Part A user's

out-of-pocket costs for hospitalization.

AARP opposed this proposal because it was in reality a mechanism for budgetary savings and only incidentally provided catastrophic protection. The irony in the Administration's catastrophic trade-off was that less than 2% of Medicare Part A users ever experience the kind of catastrophic illness capable of triggering the catastrophic protection; however, each beneficiary who reached the 61st day of hospitalization would have already paid $1,529 out-of-pocket compared with $304 under the current law.

The second proposal is the Catastrophic Expense Protection Act, S.2163 sponsored by Senator David Durenberger. S. 2163 eliminates the current "spell of illness" definition under Medicare Part A, freezes the Part A deductible at $350 for 1985 (and indexes it thereafter), levies a coinsurance rate equal to 6% of the deductible for each hospital day beyond the day of admission, and establishes a $2,500 cap on Medicare Parts A and B cost-sharing in a calendar year. S. 2163 also increases the Medicare Part B deductible to $85 in 1985 and indexes it yearly thereafter.

S. 2163 has many flaws, not the least of which is that it increases out-of-pocket costs associated with hospital and physician care for most beneficiaries while it benefits relatively few.

Under current law, the Part A deductible is scheduled to be $404 in 1985. Even though S. 2163 would "roll back" this deductible to $350 in that year, beneficiary cost-sharing

for an average hospital stay would be 44% higher in 1985 under S. 2163 than under current law. To pay less under this proposal than under current law, an aged beneficiary would have to remain hospitalized for at least 75 days. Since less than 1% of enrollees have continuous stays of more than 74 days, 99% of beneficiaries would pay more.

TABLE 1

Cost of Hospitalization	Present Law (1985)	Durenberger Proposal (1985)	% Change
11-day Stay (ALOS)	$404	$581	+44%
50-day Stay	$404	$1379	+241%
74-day Stay	$1818	$1883	+ 4%
75-day Stay	$1919	$1904	- 1%
Two 11-day Stays*	$404	$1162	+188%

*Second stay occurring within 60 days after release from first Stay

S. 2163 establishes a $2,500 cap on beneficiary liability under Parts A and B of Medicare. This cap is too high to benefit the majority of Medicare beneficiaries while the new 6% coinsurance for each hospital day imposes significantly increased out-of-pocket costs for 99% of beneficiaries:

1. On average, beneficiaries will pay approximately $400 for Parts A and B cost-sharing in 1985. Therefore, to benefit from a $2,500 cap, a beneficiary would have to incur Part A coinsurance and deductible liability at least six times greater

than the average.

2. Since only about 2% of beneficiaries incur Parts A and B cost-sharing liability in excess of $2500 in a year, very few beneficiaries would receive protection under the $2,500 cap. At the same time, 99% of all beneficiaries would pay substantially more for hospital stays, and all beneficiaries would pay a higher Part B deductible.
3. The $2,500 cap does not apply to many major forms of out-of-pocket costs incurred by beneficiaries such as charges associated with unassigned claims and expenditures for non-covered goods and services, including chronic nursing home care.

Developed by the Health Care Financing Administration (HCFA), the third proposal, like S. 2163, limits the amount of Medicare A and B cost-sharing liability to which any aged enrollee would be subject. Unlike S. 2163, however, the HCFA proposal accomplishes its catastrophic cap through the imposition of an annual surcharge on all Medicare beneficiaries. For example, in 1980 a deductible and coinsurance cap of $270 could have been financed with an annual surcharge of approximately $70 per enrollee (or an amount equal to roughly 1/3 of the average cost of Medigap policies for that year). HCFA has projected that in 1984 a cap of $400 would require a surcharge of $161 for combined Part A and Part B liability.

Beneficiary liability caps could be set at lower or higher levels by simply adjusting the amount of the surcharge.

The HCFA proposal described here has distinct advantages over the catastrophic proposals considered earlier. It distributes Medicare cost-sharing liability among all enrollees, rather than restricting it merely to the sick or injured. With no increase in program outlays, it sets maximum, predictable limits on deductible and coinsurance expenditures that are more realistic than the limit proposed in S. 2163. It also could substantially reduce the need for the purchase of certain Medigap policies by the elderly; further, it might encourage insurance companies to develop less expensive policies geared toward covering the risk of major expenditures (or catastrophic costs), rather than first dollar coverage of Medicare "gaps." And finally, it offers some peace of mind to the elderly individuals concerned about substantial deductible and coinsurance expenditures associated with both parts of Medicare.

The HCFA proposal, nevertheless, is not without its limitations. The liability against which aged beneficiaries are protected under this catastrophic plan derives only from Medicare cost-sharing requirements. The proposal does not incorporate protection for other forms of beneficiary liability such as the costs of non-covered goods and services or charges above the Medicare allowed amounts on unassigned Part B claims. In addition, elderly persons never using Medicare benefits remain subject to the surcharge. And finally, depending upon

the level at which it is set and the extent to which it reduces the need for Medigap policies, the surcharge itself could represent a significant financial burden, especially for the poor and near-poor elderly.

The Chronic Care Crisis

From the elderly's point of view, the costs associated with long term intermediate and skilled nursing home care represent the most frightening catastrophic health care expense for which they are liable. It is not realistic to discuss catastrophic health insurance coverage for the elderly without discussing coverage for long term care.

Need for Long Term Care Services

Defining a medical need for nursing home care is quite complex because the degree of this need is not the only determinant of nursing home use. Frequently, the need for nursing home care is intertwined with the elderly's housing, income, and social support conditions. A person's inability to perform basic activities of daily living appears to be a more important determinant of nursing home need than medical diagnosis. Personal care dependencies, such as assistance in bathing and dressing, may arise from an acute medical condition or from a chronic condition coupled with a factor such as advanced age. A need for nursing home care may also arise in ways other than a personal care dependency; for example, persons with certain mental disorders may need supervision to insure that they harm neither themselves nor others.

Housing, income, and social support conditions affect nursing home need because long-term care assistance can often be provided in a variety of settings that include an individual's own home, board and care facilities, and nursing homes. Obtaining care in the home may be the appropriate choice if families can provide the needed assistance within their financial and care giving capacity. The availabilty of less-intensive services also might reduce the need for nursing home care. Services such as home health care, respite care, adult day health care, and personal care homes may meet an elderly person's need. However, if such services are not available, some persons will need nursing home care because they cannot function independently at home. Even when services are available, many individuals will require such extensive support that they will seek care in a nursing home. For example, a recent study of home health care demonstration projects found that even when individuals were offered a wide array of community-based services as an alternative to nursing home care, the use of nursing home care did not decline.

Estimating the number of persons who might need nursing home care, therefore, involves a complex definition of need and extensive information regarding the service requirements of individuals, the availability of alternative means of providing these services, and the decision processes by which individuals select a course of action. Definitions, models, and data to make these estimates are not currently

available. The greatest deficiency in the present health care system is the lack of a long-term care system encompassing medical, social, and personal care services provided in a variety of community, home-based, non-institutional settings.

Because of the aging of the population, demand for long-term care services is increasing. Yet, current demand is not even being met. Today, there are an estimated 3.5 million non-institutionalized persons aged 65 and over who are "functionally dependent," and their numbers are increasing by about 100,000 a year. Fifty years from now, in 2034, there may be well over 7 million persons in this category. About one out of three of these functionally dependent older persons is homebound or bedridden. A still larger proportion are alone and isolated. Another 1.2 million older persons are in nursing homes, chronic care hospitals, or other institutions.

The elderly are better served when they are helped in maintaining their independence in their homes and communities as long as possible. Yet, the federal government spends more to maintain older persons in nursing homes than it does on the combined cost of home care under Medicare/Medicaid, all social service programs, and all federally funded special housing programs for the elderly. Moreover, although there are many programs to help older persons, they tend to be fragmented and uncoordinated. Having been separately conceived, they are separately administered with separate criteria for establishing income eligibility and need for service.

With the overwhelming proportion of available long-term care resources being consumed by high-cost institutional care, it will obviously be very difficult to build and initiate an integrated, community-based service system. But if an adequate supply of sheltered living arrangements and congregate housing, homemaker/home health care and other community-based services were available, it is likely that 30 percent of the present nursing home population could be cared for in less expensive settings. The ultimate goal, therefore, must be a long-term care program which provides a complete continuum of care and creates in the process a network of community-based centers that would function as providers, payors, certifiers and evaluators of services.

Unfortunately, there are few options available to older people to acquire long-term care protection. Medicare nursing home protection is strictly limited, both in duration of protection and level of care, as well as in setting. Medicaid, on the other hand, provides a broader long-term care benefit, but requires beneficiaries to "spend down" most of their resources before Medicaid will provide any benefits whatsoever. Indeed, Medicare and Medicaid together finance only about fifty percent of the long-term care provided in this country. The remaining fifty percent is financed by nursing home patients directly out-of-pocket. Forcing long-term care patients into poverty before benefits will be provided is the reason why long-term care is the major catastrophic health expense of the elderly.

The private insurance market has yet to develop long-term care insurance with meaningful benefits at a reasonable cost. For the future, increased private sector involvement in meeting long-term care needs must be forthcoming. Private insurance companies should be encouraged to add long-term care benefits to existing policies and develop new policies which would specifically address the elderly's long-term care needs. Over the long term, health insurance accounts (similar to tax-deferred IRAs) could be created providing younger persons with an incentive to save for their future long-term care needs.

Summary and Recommendations

While the development of a viable and coherent catastrophic insurance program for the elderly presents certain nettlesome definitional and financing problems, nevertheless the need for increased protection of the elderly against catastrophic costs is clear. And while it is not easy to quantify human misery, or, for that matter, "financial ruin", the evidence clearly suggests that each year hundreds of thousands of older Americans face devastating health bills as the result of acute medical crises, bills that are not always covered by Medigap policies or by Medicaid. (Only two-thirds of the elderly are protected by some form of Medigap coverage and only one-fourth of the non-institutionalized poor or near-poor elderly qualify for Medicaid benefits.)

Further, given present trends toward increased longevity as well as changing social patterns that deemphasize family responsibility for the elderly, the need for the protection of this population against the high cost of long-term care for chronic and degenerative conditions is perhaps more pronounced than for acute care crises. Since few Medigap policies provide coverage for long-term nursing care at the intermediate level, and since Medicaid and Medicare combined cover only one-half of all expenditures for nursing home care, increasing numbers of elderly citizens will be at risk in the future for costly and protracted periods of institutional care. Today, one out of every four Americans will use nursing home services during his lifetime with an average length of stay in excess of 450 days.

Further, few alternatives to institutional care are available for those dependent elderly individuals who require on-going medical or custodial support. Indeed, the present reimbursement system encourages the use of institutional care over less costly, and frequently more appropriate and more humane, community-based care.

AARP believes that there is a serious, demonstrable need for catastrophic health insurance coverage for the elderly, most pronounced in the area of long term care. At this point, however, the Association urges caution in incorporating expensive new commitments into Medicare when the program is headed for insolvency and the federal government faces huge budget deficits. AARP believes that the most urgent (catastrophic) need for Medicare is to put the Program on a viable financial footing.

The Association recommends that the restoration of Medicare to a sound financial basis be accomplished by controlling cost escalation in the health care system, especially escalation in hospital costs. The federal government, as a major purchaser of health care services, cannot shrink from its responsibility to abate explosive cost escalation in the health care sector. Since approximately 75 percent of all Medicare expenditures are for hospital costs, the federal government has the market power and the financial interest to abate the excessive rate of hospital cost increases.

The Association accordingly recommends across-the-board limits on increases in hospital costs and physicians' fees. It

further recommends that Congress actively encourage states to adopt mandatory hospital rate review programs. Significant cost savings have been demonstrated in the six states with mandatory rate review systems. During 1982 and 1983, hospital expenditures in those six states rose at a rate that was one-third less than that of non-regulated states.

During this period of across-the-board cost-containment, the Association urges that policy efforts be directed toward the development of viable catastrophic coverage for the elderly. Additional research should be conducted updating and augmenting the 1977 National Nursing Home Survey in order to permit responsible and responsive planning for long-term catastrophic illnesses and impairments. Further, additional data on out-of-pocket expenditures by the elderly for non-covered goods and services would also afford a more complete look at full beneficiary liability for both acute and long-term medical conditions.

In addition, the Association encourages the development of appropriate models and data to estimate the population in need of care in order to ensure responsible allocation of existing resources. It strongly supports the development of demonstration and model projects that would explore options to costly, and sometimes inappropriate, institutional care for those elderly who are functionally dependent.

Finally, the Association strongly urges skepticism in implementing catastrophic protection plans for the elderly

that benefit few while imposing significant financial hardships on many. It encourages the fashioning of a catastrophic plan that responds to the real needs of the elderly, not one that is simply a mechanism for benefit reduction or increased beneficiary cost-sharing.

The Association appreciates having had this opportunity to present the Association's views on catastrophic health insurance coverage for the elderly.

Senator BENTSEN. Thank you very much, Mr. Hacking.
Mr. Merrill, please proceed.

STATEMENT OF JEFFREY C. MERRILL, DIRECTOR, CENTER FOR HEALTH POLICY STUDIES, GEORGETOWN UNIVERSITY, WASHINGTON, D.C.

Mr. MERRILL. Thank you, Mr. Vice Chairman. I, as the others, do have a prepared statement which I will submit for the record. My remarks today will be very brief.

A lot of what was said today I would very much agree with, particularly the notion that we often confuse what we mean by catastrophic illness and catastrophic payments under the program. I think that the problem is a lot more widespread than simply the person with the very long-term acute illness. It affects a great number of the people in the program.

To put that in some context, I would like to try to discuss very briefly some of the realities of the medicare program and why this has emerged.

First of all, I think it is important to understand that medicare was never intended to meet all the health needs of the elderly and disabled. Rather, the program was intended to protect against acute illness and not against chronic illness. I think some of the expectations are too great.

Second, the program was initially conceived as a very complex patchwork quilt of coverage limitations, deductibles, copayments and coinsurance requirements, which not only reflected the private insurance model on which it was based, but also, ostensibly, were imposed to restrain overutilization of services.

Third, as the program has evolved, its complexities have not been removed. What has occurred is the patchwork quilt has simply gotten larger and no serious attempt has been made since 1972 to restructure the program significantly.

When I went to the Health Care Finance Administration where I served as Associate Administrator, somebody told me very early on that the program is often viewed as the Bible and that the 1965 law was the Old Testament and the 1972 amendments was the New Testament and that any major changes would therefore be sacrilege.

Given this, the gap that exists between the rising costs of medicare and the lesser coverage over the years is really a function of a complex web of coverage rules and cost-sharing requirements combined with a health system that grows at a rate considerably faster than inflation. The impact of this on the provider is confusion, added administrative costs and, often, a desire not to participate directly in the program. The impact on the beneficiary is even worse in terms of confusion, anxiety, and increasing financial burden.

Let me give some examples of what I mean by catastrophic and how this burden is felt. This will reinforce some of the things that have already been said.

Someone with an 85–day hospital stay under the program will be responsible for almost $2,600 in out-of-pocket expenses, even given the coverage of the program; for a 120-day stay, the cost-sharing is almost $8,400.

Second, a post-hospital stay in a skilled nursing home of 100 days would involve costsharing for the beneficiary of $3,560. Ironically, the cost of a 100-day-stay nursing home is approximately $7,500, given the average around the country, so that the beneficiary would pay almost half of that total amount and in some places pay more because the cost sharing is fixed regardless of the actual payment.

Third, over 11 percent of all aged medicare beneficiaries this year will be responsible for an average of almost $1,700 out-of-pocket for just physician and related services not covered under part B of Medicare. This has nothing to do with hospital stays. This is simply what they will be responsible for in terms of physicians and related services, and almost $700 of that will be for unassigned claims that would probably not be covered even it they did have medigap insurance.

Fourth, approximately 2 percent of the elderly, even if all their claims were assigned and all the services they used were covered under medicare, would be responsible for an average of $2,000 a year under the program, and if they are a medicare disabled person, over 2 percent would be responsible for over $5,500.

We are not only talking about the extreme cases; we are talking more about, in both cases, a fair amount of the population. These are only examples for illustrative purposes. What they do not reflect is the anxiety of the average beneficiary who may not have this problem now, but foresees it in the future.

We have talked about medigap and the potential of that. I just wanted to put that into some perspective.

First of all, medigap coverage varies widely. When we talk about medigap, we are not talking about a single plan. While most medigap coverage does involve hospital expenses, the inpatient side, only 60 percent cover nonhospital visits. Few of these plans pay, on unassigned claims, the difference between what medicare pays and what the physician charges, and there is little protection against things like dental care, outpatient drugs, and long-term care.

Second, while 75 percent of the middle- and upper-income elderly have private insurance, only 50 percent of the poor have such coverage.

Third, while over 90 percent of those covered have supplementary insurance for inpatient care, only 25 percent of the population

has coverage for care beyond the 90th day of a stay. So that the costsharing of those copayments beyond that remain a very significant burden for even the covered population.

Last, the cost of medigap is very high. In 1983, typical premiums were about $200 to $500, but the cost of more comprehensive coverage which would address some of these more catastrophic issues was often between $800 and $1,200 a year.

Also, as has been mentioned, to compound this problem, as we try to look for solutions we are confronted with a hospital insurance fund that has potential bankruptcy and a budget deficit in which medicare is clearly playing some role in possibly reducing it. So we cannot look simply to increased coverage to find the solution to this problem.

We have really got somewhat of a paradox. We have the need to reduce program costs while at the same time adding coverage or protection for beneficiaries.

I want to propose three generic solutions to this and then describe one specifically. These three are not things I necessarily endorse; I just think they are three possible ways of dealing with this paradox.

If you are going to increase protection against the catastrophic costs of health care, in order to offset that, you can increase costsharing or reduce benefits so that, while one may have to pay more initially, that individual will have the security of protection against catastrophic illness. And the two preceding speakers I think spoke very eloquently as to why that may not be a desirable solution.

Second, you can spread the risk across the entire medicare population by increasing premium amounts paid into the program or taxing the elderly, as the social security bailout proposal did for the OASI fund.

Third, you can spread the risk through the entire population, either through payroll, targeted excise, or general income taxes.

The President has suggested the first of these proposals, which is basically to provide some backend catastrophic coverage but at the frontend put more costsharing. I do not want to beat a dead horse, but I think something should be pointed out. Basically, that the President's proposal penalizes the sick because, if you are not sick, you do not pay anything extra under that. What it does, also, is penalize those people who are the oldest and the poorest, because there is a high correlation between the older the person is, the poorer.

As an example, for people 65 to 74 years old in 1981, only 20 percent of them used hospital services, while for people over 85, 34 percent did.

Senator BENTSEN. Let me have those numbers again.

Mr. MERRILL. In 1981, for the population that was 65 to 74 years old, the younger portion of the medicare population, one in five of them used hospital services; in other words, took advantage of the part a benefit in that year. On the other hand, more than a third, 34 percent, of those people over 85 used the hospital benefit. So the older you are—and the number is continuous—the older you are, the more you use.

Second, in terms of income, people 65 to 72 that year had a median income of $10,800. People over 80 had an income of $7,400. That income distribution has not changed in the interim.

So that proposals that provide more costsharing are really redistributive in the sense they are penalizing those older, and poorer, and sicker in favor of those younger, and less sick, and less poor.

I want to offer an alternative. At least a short-term and maybe a quick-fix solution, but I think on with some benefit in a number of ways.

I believe that a better alternative to imposing such high and uncertain costs on the sick would be to allow the aged to purchase additional health insurance directly through the medicare program. Since this approach spreads health costs across the whole medicare population, the added coverage could be provided at a modest and budgetable expense.

Let me give you an example. The catastrophic hospital insurance covering the current costsharing beyond the 60th day of hospital care would cost only $3.25 per month in 1984 if provided directly by the medicare program. By the way, it would also deal with a lot of the complexities of the program in terms of spell of illness requirements and when people are entitled to a new start of benefits. Things like that could be eliminated. This proposal could also cover everything beyond the second deductible.

Medicare insurance to cover the 20-percent coinsurance under part B would cost about $15 a month. Therefore, the cost of these two which provide basically for filling in all the gaps for medicare is about $20 a month. When you consider medigap last year I think was about $490 a year or $40 a month, this is considerably less expensive.

Also medicare already collects premiums. Part B is an insurance program and since the premiums are collected through deductions from the social security check, this would not require a new administrative mechanism to accomplish this. You could simply add on to what you have.

Also, medicare's administrative costs, contrary to what a lot of people think, are very low. They are about 2.2 percent of benefit costs. So in a sense, you could provide a lot of protection with very little add on for administrative costs.

Another advantage to this approach, in my opinion, is that it eliminates some of the complexities that plague the current program. The difficulties of coordination of benefits between medicare, medigap insurers, and direct-patient billing could be reduced. In other words, if a physician took assignment and they submitted a bill to medicare, they would simply get 100-percent payment from medicare. The physician would not have to bill the patient and the patient would not have to worry about the responsibility of billing to other insurance companies if they did have such coverage.

In that way it may make acceptance of assignment even more attractive to physicians because it will eliminate a lot of their own double-billing concerns.

Further, program administration would be simplified by eliminating such complexities as spell-of-illness requirements and direct billing of patients for lengthy hospital stays.

For low-income people, medicaid picks up the part B premium already and this simply could add on to that so medicare supplementals could be covered for low-income people. This proposal could cover those added services simply through that buy in at the medicaid level.

I do not want to portray this as the only or the perfect solution, nor does this solve all the problems that relate to catastrophic coverage, particularly those concerning provision of long-term care. Nevertheless, I believe that, at a time when the Federal Government's ability to maintain medicare's current benefits seems increasingly doubtful, it is imperative to find better ways to assure that the elderly and disabled will be able to pay for their own health care. By offering new options for purchasing supplemental insurance through medicare, at least we can help assure that current protection against catastrophic illness is available and, if we need to make future modifications in the program to reduce program expenditures, this may be a vehicle to ease that burden for the elderly. Thank you.

[The prepared statement of Mr. Merrill follows:]

Prepared Statement of Jeffrey C. Merrill

Mr. Chairman, members of the Committee, I am Jeffrey Merrill, Director of the Center for Health Policy Studies at Georgetown University Medical School. Prior to my current position, from 1978 to 1981, I was the Director of the Office of Legislation and Policy at the Health Care Financing Administration. The issues you are discussing today have long been a concern of mine and I am pleased to have the opportunity to share my ideas with you.

Next year will mark the 20th anniversary of the Medicare program. As we approach that date, we are confronted with a problem which, while not new, has recently become more immediate and severe. Although growth in Medicare has been continuously dramatic, there has been no similar reduction in the financial burden on the elderly in meeting their health care needs. To illustrate this apparently paradoxical problem, I would like to share some data with you.

As we all have observed, Medicare costs have risen faster than overall inflation. This fact is not remarkable in itself. Rather, it is remarkable because there appears to be no abatement in that growth: between 1978 and 1983, in real terms, Medicare outlays grew at the phenomenal rate of 9.8% per year. However, the Administration projects that, between 1983 and 1985, the rate will, in fact, increase to 11.4% annually, despite efforts by the Congress to contain Medicare costs.

Yet, with all this growth, the share Medicare actually pays for services covered under that program has, in fact, declined

slightly. In 1981, the last year for which data are available, Medicare covered approximately 68% of hospital and physician costs for the elderly. This was down slightly from about 69% in 1978. Further, in 1981, Medicare only covered 55% of the average beneficiary's physician bills. In addition, Medicare's share of the total cost of health care to the elderly has remained at about 45% over the last few years.

Why does this gap exist despite the rapid rise in Medicare payments? More importantly, what are its implications for the burden the elderly must bear with respect to their health costs?

To answer these, I believe certain basic notions regarding the Medicare program must be understood:

1) Medicare was never intended to meet all the health needs of the elderly and disabled. The program was essentially modeled after the Blue Cross/Blue Shield program and, as such, was intended to protect against acute episodes of illness, not against chronic illness.
2) The program was initially conceived as a complex patchwork of coverage limitations, deductibles, copayments and coinsurance requirements which not only reflect the Blue Cross/Blue Shield model, but ostensibly serves to restrain overutilization of services.

3) As the program has evolved, its complexities have not been removed but, rather, have been further complicated by changes that are often made in the name of greater simplicity. No serious attempt has been made since 1972 to restructure the program; instead, these changes have only occurred on the margin. Someone once likened the Medicare statute to the Bible with the original 1965 law being the Old Testament and the 1972 Amendments the New Testament. Thus, to suggest making any major changes to such a holy document is considered sacrilegious. (Extending this analogy, maybe the recently enacted Prospective Payment System might be considered the Apocrypha.)

Thus, both the beneficiaries and the providers of service are confronted with a confusing and often contradictory program. Confusing to anyone who has tried to interpret the Explanation of the Medicare Benefits which is sent to the beneficiary when a claim is paid. Contradictory in the sense that the program, on the one hand, limits the number of post-hospital skilled nursing home days for a beneficiary to 100, but pays for an unlimited number of home health visits.

The gap between what Medicare covers and the level of payments made by the program is a function of a complex web of

coverage rules and cost-sharing requirements combined with a health system that grows at a rate considerably faster than inflation. The impact of this on the provider is confusion, added administrative costs and, often, a desire not to participate directly in the program. The impact on the beneficiary is even more confusion, anxiety, and increasing financial burden.

How catastrophic is this burden? Let me provide some examples:

1) To the patient who has spent more than 60 days in the hospital this year, each day will cost $89 for the next 30 days and then $178/day for each day thereafter. After 150 days, there is no longer any Medicare coverage. For instance, someone with an 85 day hospital stay will be responsible for $2581 in out-of-pocket expenses; for a 120 day stay, the cost-sharing would total $8366.
2) While post-hospital skilled nursing care is a benefit covered under Medicare, each day beyond the 20th day of a stay requires a copayment of $44.50/day. Thus, a post-hospital stay of 100 days in a skilled nursing facility would involve cost-sharing amounting to $3560. Therefore, since the average cost of 100 skilled nursing facility days is about $7500, the

beneficiary may be responsible for more than half of the total bill.

3) While 80% of reasonable physician charges is covered by Medicare, over 11% of all aged Medicare beneficiaries will be responsible for an average of almost $1700 for physician and related services not covered under SMI. Of this, almost $700 will be for charges on unassigned claims, most of which will not even be covered by Medigap insurance.

4) Approximately 2% of the elderly, even assuming that all their Part B claims were covered and assigned, would be responsible for an average of $2000 this year for services billed under Part B. For the Medicare disabled, given the same assumption, over 2% would be responsible for about $5500.

These examples are for illustrative purposes and do not necessarily reflect the situation for the average Medicare beneficiary. Nevertheless, the possibility of any beneficiary confronting such a crisis is ever-present and remains a continuing source of anxiety for them.

In response, a large portion of Medicare beneficiaries seek protection, through the private insurance market, against a financially catastrophic health problem. About two-thirds of the

elderly are covered by some form of Medigap insurance. In addition, about 13% of the elderly are protected by Medicaid, which acts as a supplement to Medicare for the poorest of the elderly.

Thus, there is some protection for many of the elderly against the cost of care that Medicare does not cover. Unfortunately, this is not without problems:

1) Medigap coverage varies widely. While almost all of the plans provide some protection against hospital expenses, only 60% cover non-hospital visits. Few of these plans pay, on unassigned claims, the difference between what the physician charged and what Medicare paid (they usually only pay the 20% coinsurance). Lastly, little protection (only 9% of the plans) is available for dental care and for coverage of out-patient drugs and nursing homes.
2) While more than 75% of the middle and upper income elderly have private insurance, only 50% of the poor have such coverage.
3) While 90% of those covered do have supplementary insurance for inpatient care, only 25% have any catastrophic coverage, i.e., coverage beyond Medicare's 90 day limit on hospital days within a given spell of illness.

4) For those who do purchase Medigap insurance, the costs are very high. Typical premiums in 1983 were in the $250-$500 range (depending on extent of coverage and whether the insurance was under an individual or group plan). The cost of more comprehensive coverage is considerably higher: $800-$1200/year. In 1983, about 17 million elderly paid an average of $490/year for Medigap coverage.

We are confronted with the problem of increasing public expenditures, yet no relief for the elderly as a result of the growth in Medicare. Further, while the private insurance industry has relieved some of that burden, the cost of such protection is high and the extent of coverage varies greatly.

To compound this dilemna, there is considerable pressure to reduce the current Medicare program as a means of both shrinking the overall Federal deficit and seeking a solution to the potential bankruptcy of the Medicare Hospital Insurance Trust Fund. To date, the Medicare Part B deductible and premiums have been raised and, currently, a variety of proposals are being discussed which, if enacted, would shift even greater costs to the beneficiary. Also, changes such as increasing the deductible lead private insurance premiums to rise as well.

These problems are clearly not new. Yet, they are getting increasingly serious. Unfortunately, there is no quick fix, no

straightforward solution. And, any solution must achieve two apparently contradictory goals: Reducing program costs while increasing protection for the elderly.

While I believe major structural changes in Medicare are necessary, I am not here today to discuss a total overhaul of the program. Instead, I would like to focus my remaining time on a proposal which I believe might alleviate some of the problems for the elderly without an adverse financial impact on the program.

In doing so, I believe it is important to understand what approaches are available to address this problem. If we are to increase protection against the catastrophic costs of health care, we must find savings somewhere else. There are three generic options available to us:

a) Increase cost-sharing or reduce benefits so that, while one may have to pay more initially, he/she will have the security of protection against catastrophic illness.

b) Spread the risk across the entire Medicare population by increasing premium amounts paid into the program or taxing the elderly, as under the Social Security bailout.

c) Spread the risk through the entire population, either through payroll, targeted excise, or general income taxes.

The President, for example, in his FY 1984 Budget reflected his concern about the lack of catastrophic coverage and chose the first of the above options as part of his solution. He proposed the the provision of catastrophic insurance for hospital stays over 60 days but, to pay for this, he suggested the imposition of new out-of-pocket costs for the first 60 days of hospital care. Overall, that proposal would have actually saved $700 million for Medicare in 1984, and $1.7 billion annually by 1988.

Whether one agrees or disagrees that the Federal budget problems justify shifting costs to the elderly, the Reagan proposal did represent an option on how to add some catastrophic protection for the elderly. However, in doing so, beneficiary's costs for an average hospital stay would have risen from $350 to $630 in 1984--and the maximum liability would be $2324 per person. At the same time, no protection would have been provided for the unlimited out-of-pocket expenditures which can result from the gaps in coverage under the physicians' insurance portion (Part B) of Medicare.

Furthermore, under this option of increasing cost-sharing, a larger burden would have fallen on the older (above 75) elderly for they tend to incur the most hospitalization and also have the lowest incomes. In 1981, for example, only 20% of Medicare beneficiaries 65-74 years old needed hospital care, while 28% of

those 75-84 and 34% of those over 84 used this benefit. For that same year, the median income for people 65-72 was $10,800; for individuals 73-79 it was $8500; and for those over 80, $7400.

I believe that a better alternative to imposing such high and uncertain costs on the sick would be to allow the aged to purchase additional health insurance directly through the Medicare program. Since this approach spreads health costs across the whole Medicare population, the added coverage could be provided at a modest and budgetable expense.

This approach builds on the current structure of Medicare's supplementary medical insurance (SMI) program which already has a premium built into it. Thus, no new administrative mechanism would have to be established to collect premiums for the added coverage. Further, this option would take advantage of Medicare's very low administrative costs, now about 2.2% of benefit costs. Private insurance is more costly to administer because of marketing and other expenses that must be built into the premium rates.

For example, catastrophic hospital insurance covering the current cost-sharing beyond the 60th hospital day would cost only about $3.25 per month in 1984. Medicare insurance to cover the 20% coinsurance under Part B would cost about $15 month. Thus, filling in the basic gaps in Medicare coverage would require a premium of about $20 per month. Parenthetically, even if the

Reagan proposals were adopted, insurance against the added cost-sharing for shorter stays could be provided for $4.50 per month.

Savings for the elderly can also be achieved because the Medicare program is already handling nearly all of the aged's hospital and physician bills, and thus would not have to create new mechanisms to provide such coverage. Also, as indicated earlier, enrollment and premium collections could be handled automatically, as is now done for the SMI program through monthly deductions from the Social Security check.

Another advantage of this approach is that it eliminates some of the complexities that plague the current program. The difficulties for beneficiaries, physicians and hospitals concerning coordination of benefits between Medicare, Medigap insurers, and direct patient billing could be reduced. Physicians willing to take assignment would receive 100% of the reasonable charge directly from Medicare and would no longer have to bill the beneficiary or another insurance company for these. This might even make acceptance of assignment more attractive to physicians. Further, program administration would be simplified by eliminating such complexities as "spell of illness" requirements and direct billing of patients for lengthy hospital stays.

If government budget problems force future erosion of Medicare benefits, this approach offers the elderly an excellent way to purchase health insurance to fill those gaps. As I have already mentioned, about 67% of the aged now purchase some form of private Medigap insurance, paying an estimated $8.4 billion in premiums in 1983. The low Federal costs of Medicare add-on insurance could save the elderly and disabled more than a billion dollars annually for current coverage and even greater amounts if self-paid insurance protection must be increased in the future.

For those low-income Medicare beneficiaries who are covered under Medicaid, States would be able to purchase this optional coverage in the same manner as many do now to pay the SMI premium for that population. As well, if means testing of Medicare must be considered, it would be easier to link this to premiums, which are knowable and budgetable, rather than to try to achieve that through greater deductibles or benefit reductions.

I do not intend to portray this as the only--or perfect--solution. The problem is complex and will require complex solutions. Further, this proposal is not without problems, for no approach will please everybody: beneficiaries, providers, and users. Lastly, many of the issues of catastrophic care will not be addressed by such a plan, particularly those concerning the provision of long-term care.

Nevertheless, I believe that, at a time when the Federal government's ability to maintain Medicare's current benefits seems increasingly doubtful, it is imperative to find better ways to assure that the elderly and disabled will be able to pay for their own health care. By offering new options for purchasing supplemental insurance through Medicare, at least we can help assure that current protection against catastrophic illness is available and, if future modifications designed to reduce program expenditures are necessary, the elderly may be better able to absorb them.

Senator BENTSEN. Mr. Merrill, that is a very interesting proposal, and I find it rather appealing. But that is why I have Mr. Shapland next. He may tell me why it will not work well.

Mr. MERRILL. Shall I give him the microphone? [Laughter.]

STATEMENT OF ROBERT B. SHAPLAND, VICE PRESIDENT AND ACTUARY, MUTUAL OF OMAHA INSURANCE CO., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA)

Mr. SHAPLAND. Good morning. Thank you for the opportunity for being here. I, too, have a prepared statement which I will submit and try to make some very brief remarks. Actually, my remarks probably will not follow my prepared statement but I will try to tailor my remarks to the conversations that have been going on here at this hearing.

The health-insurance industry shares the concern for the catastrophic-cost problem facing the elderly. Hearing some of the figures that have been quoted here leads me to believe that maybe we need to look at those figures very closely and maybe even gather some more figures to find out——

Senator BENTSEN. Are you reading from your prepared statement?

Mr. SHAPLAND. I am not following it at all.

I think that there has been a lot of interesting statistics thrown out here. It seems to me we might need even more about what the correlations are between people's incomes, the expenses they are being faced with, and the distribution of those expenses. In trying to find a solution that meets the need we have to fully understand what the needs are.

As I said, the insurance industry shares the concern for the catastrophic needs and it has been foremost in meeting those needs through the supplemental policies. Many of the health-insurance association members sell medicare supplemental policies. My company happens to be one of the leaders in that. Those policies by law basically meet the catastrophic needs on the hospital side. There was an amendment which said that when you sell a medicare sup-

plemental policy you have to cover all the coinsurance amounts and cover hospital expenses at 90 percent after medicare runs out. A lot of our policies cover 100 percent.

So the citizen has the ability to cover catastrophic illness if he wishes to do so and, as has been pointed out in the hearing, 70 or 80 percent of those not covered by medicaid are doing so.

A lot of companies sell those policies completely without any health questions, like my company does. Thus, even if you are not healthy you can buy that coverage. So there is a system already in place for sharing amongst all the people over 65 the catastrophic costs without having just the sick ones pay that cost.

I would suggest examining the 20 percent who are not buying catastrophic coverage to see if they are not buying it because they do not want it, or because they do not need it, or because they need some encouragement. We should not try to find a solution for 100 percent of the people when we only need a solution for 20 percent.

Medicare supplement policies offered by the industry are also made available to cover drugs, and nursing home coverage, and so on. Those things were mentioned as things outside of medicare that face the public and some of our policies cover those things.

As has been mentioned here, in any search for solutions and examination of solutions, one of the key things that should be taken into account is the financial solvency of the medicare program as it stands now. It is nice to talk about expanding benefits, but I think we have to find financial solutions to the program that we already have. There may be some merit in restructuring medicare because that is the whole foundation of insurance in the first place. The whole purpose of insurance is to cover costs that cannot be budgeted for, especially the catastrophic costs. Those are the ones that can not be budgeted for. So there is some validity to the thought that you could put some more coinsurance in at the frontend and take out the catastrophic cost at the backend without hurting the financial plight that the medicare program is already in.

As stated, that would shift the catastrophic costs to more people, but it would still shift it to just the sick ones. However, over the years just about everybody is sick some time or other. The frequency of hospitalization is very high.

We share the feeling that has been expressed here that the ability to pay should probably be researched. That same concept was just adopted under the retirement program. Under that program social security benefits were made taxable for persons at the higher income level. So there was a shift of the burden of the cost to those that have the ability to pay and I think that that same philosophy needs to be studied in meeting the medicare-financing problems.

I think if we are going to do that, maybe some kind of a study commission or whatever should be appointed to figure out a fair system to do that. We have questions of what income should be reflected in measuring ability to pay, what assets should be used in measuring ability to pay and so on, and I think the concept of ability to pay is one that should be considered and some study be given to and try to do that on a practical basis.

Aside from all these, our industry feels that one of the key things to do is to control costs for all citizens. That is going to help the elderly and it is going to help the younger people. It is going to

help everybody. We need to spend a lot more energy on the cost containment side and we should not do it on the basis of just shifting costs from one segment of society to another. We should get involved in cost containment systems that affect everyone.

Along these lines, there are so many things that have been proposed and so many things that we have not thought of that we think that cost containment proposals should be structured on a basis that would allow the maximum experimentation and innovation. We think this would be accomplished by attacking cost containment through the States—let each State work out their cost containment. They will each go their own way, but each State can learn from the successes and failures of the others and we think we need some incentives from the Federal side so that States can get involved with cost containment.

Just to give you an idea of the breadth of cost containment things that are already taking place, to give you an idea of the need to have some flexibility in cost containment, I thought I would just mention a couple that I happened to write down on the plane coming in. A prospective-payment system. I think you are aware of that. We have preferred provider organizations that are coming forth in California and other places where we are negotiating with providers to charge lower prices. That is forcing providers to economically provide the care they can give at those lower prices. We have utilization review, peer review. Some of the preferred provider organizations are requiring preadmission examinations. If you are going to be put in the hospital, somebody is going to review it to see whether you really need to be in that hospital and then continue to review after you are in the hospital. We have second surgical opinions and programs that are trying to get cheaper types of care replacing the more expensive care, like surgical centers, home-health-care programs, free standing emergency centers, preadmission testing, and outpatient services before you go into the hospital. There you are talking about chemotherapy programs in doctors' offices instead of hospitals.

Then there is a movement to give people a financial incentive themselves to avoid unnecessary care or to take care of themselves through a bonus program where you get a reduction in your premium if you do not have claims and things like that. And there are all kinds of wellness programs.

I think we need to spend a lot more energy keeping people well so we do not have these medical costs—health education programs and fitness programs.

That is the end of my testimony.

[The prepared statement of Mr. Shapland follows:]

Prepared Statement of Robert B. Shapland

My name is Robert Shapland. I am Vice President and Actuary of Mutual of Omaha. Today, I am speaking not for my Company but on behalf of the Health Insurance Association of America (HIAA). This association is a voluntary trade association representing approximately 340 insurance companies which write about 86% of the private health insurance business in the United States. Many of our members provide various forms of insurance coverages to Medicare eligible persons. In 1982, about 14 million persons over age 65 were covered by private health insurance. This means we have a substantial interest in any changes made in the Medicare program.

We all recognize that our gross national product does not support a risk-free, want-free society. Governmental agencies, business, and private citizens must all cope with living within their means. Under the Medicare program, actuarial projections show that in the near future, the cost of the program will greatly exceed revenues and therefore changes must be made. The decisions needed to bring about financial stability will not be easy because they will call for some segments of society to bear the financial burden of any change. Because of our industry's vast experience with the design of insurance programs for citizens of all ages, our work on cost containment, and our actuarial and other administrative skills, we offer our assistance in researching solutions.

At this time, the HIAA has not analyzed the possible solutions in sufficient depth to take a definite position in endorsing or rejecting them nor has it attempted to prioritize the various alternatives. Our purpose here

today is only to outline some of the corrective measures that have been suggested by others that might be considered in order to achieve financial stability. We suggest that they be studied carefully before coming to any conclusions.

In studying possible solutions, we believe there are some basic premises that should be kept in mind. The first is that the concept of Medicare is to provide a floor of protection. This is a similar concept to that being followed under the Social Security retirement program. In this regard, government statistics indicate that Medicare benefits are currently paying approximately 44% of the medical bills of citizens over age 65.

Second, because the Medicare program is designed to provide a floor of protection, private industry and individual responsibility should continue to play an important role in meeting total medical care costs. The floor of protection concept and the responsibility of individuals to provide for part of their costs stem not only from the limits on the government's financial ability to provide full coverage but the overall commitment to maximize freedom of choice and individual responsibility in all aspects of life in the United States.

Third, an increase in the use of general revenue financing should be avoided. We believe social insurance programs should be funded by direct taxes in order to avoid burying their cost in the morass of general revenues and deficit financing which in turn can lead to insufficient recognition of their long-term costs.

Fourth, the practical problems in bringing about a revenue/expenditure balance require an examination of a broad range of methods and the possibility of using a composite of these methods as the final choice. The various methods that have been proposed to achieve a financial balance include:

- Lower benefits.
- Higher taxes.
- Cost containment.
- Evidence of need.
- Higher Medicare premiums.

Fifth, any solution utilizing cost savings should be real as opposed to being based on cost shifting. Cost containment activities should extend to all patients.

Finally, but certainly not least in importance, special care must be given to the needs and financial situation of the elderly.

In this context, the following is a list of some of the corrective actions that have been proposed. Again, I want to make it clear that the HIAA has not

completed its study of these proposals and therefore neither endorses nor opposes them at this time.

1. The adoption of coinsurance payments for the first 30 or more days of hospitalization following the initial deductible. This would be compatible with the concept of continuous coinsurance under the supplementary medical insurance (Part B) portion of Medicare where coinsurance cost containment incentives are maintained throughout the duration of an insured's medical care. When adopting such coinsurance, consideration could be given to decreasing the coinsurance as the length of stay increases to avoid the buildup of an excessive coinsurance burden on citizens with unusually long hospitalizations.

   Along these lines, it has been suggested that consideration be given to adding catastrophic coverage to the hospital program. This means adjusting the program to remove the current durational limits and pay a high percent, possibly 100%, after a given duration in order to avoid exposing insureds to catastrophic expenses. It might be noted that if additional coinsurance is used to reduce Medicare benefits in an effort to bring about financial stability, the cost of any added catastrophic coverage would have to be less than the savings from the coinsurance in order to realize that goal.

2. The indexing of the Part B deductible amount. This would maintain a reasonable level of cost containment incentive in an inflationary environment and lessen the impact of inflation on Medicare costs. This would be consistent with the current handling of the Part A deductible.

3. The introduction of the "ability to pay" into the financing structure of the Medicare program. This philosophy was recently adopted under Social Security retirement benefits when such benefits were made taxable.

   Since it might be desirable to design a system where revenues vary based on ability to pay, a study could be undertaken to work with welfare agencies, the IRS, etc., to determine a fair and practical system to measure ability to pay.

4. Increasing the age of entitlement to Medicare benefits. This approach is similar to that being taken under retirement benefits. This increase is in recognition of the ever-expanding life expectancy of our citizenry and the resulting increase in the relative number of persons over age 65 compared to the working population under age 65.

5. One proposal for restructuring Medicare benefits and finances to meet upcoming financial problems has been suggested by the Advisory Council on Social Security. Their proposal includes extending Part A to cover all hospital days, the adoption of coinsurance during the first 60 days, placing a $200 out-of-pocket limit on Part B expenses and the elimination of Part B benefits if insureds don't purchase coverage supplementing the Part A coinsurance amounts. In addition, the premium charged to Medicare eligibles would be increased dramatically.

   There may be several problems with this approach. First, the choice of purchasing coverage supplementing Part A vs. losing Part B benefits seems inappropriate. Second, the dramatic increase in premium may be beyond the economic means of many retired citizens and thus deny them their current Part B benefits. Third, the supplemental insurance option could falsely lead the elderly into believing that private insurance is unnecessary even though Medicare would still not cover a large share of their medical expenses. Fourth, the premise of their proposal that private insurance is confusing and duplicative is invalid. Fifth, the viability of private supplemental insurance would be reduced which would adversely affect the public service work of our agents in explaining the Medicare program.

These proposals to revise the benefits, eligibility, deductibles, co-payments and premiums all involve a re-shuffling of who pays the medical bills for the over-65 population rather than attempting to overtly reduce the size of the nation's medical bill itself. The Health Insurance Association of America strongly supports instead measures designed to reduce, or at least slow the rate of increase of, the cost of health care for all Americans, such as:

1. An increase in cost containment activities. This could include restraints on both prices and utilization. For example, such efforts could include:

    a. Expanded utilization review for all types of care.
    b. Search for more economical delivery systems.
    c. Expansion of economic incentives to restrain prices and utilization by placing providers at financial risk (e.g., via PPO organizations and prospective DRG systems).

2. The expansion of wellness programs. This could include:

    a. Expansion of educational program regarding diet, exercise, etc.

b. Financial incentives to maintain health, possibly through bonuses or reduced premiums for those not submitting claims.

c. The expansion of fitness programs.

The Congress took a major step forward last year towards slowing the rapid increases in hospital costs by enacting a prospective pricing system for Medicare, thereby giving the hospitals much greater incentives and rewards for efficiency and cost consciousness.

We urge the Congress now to take the next step on prospective pricing - to enact legislation extending a hospital prospective pricing system to all payers, not just Medicare, to take effect four years after enactment in any State which has not enacted a qualified State program. Such legislation would give every State time to enact legislation suitable to its own particular needs and yet guarantee that all our citizens get the protection they deserve. It would provide a stimulus to those who believe our problems are best solved at the State level to move ahead and get the job done there so there will be no need for a Federal all-payer program.

We urge the Congress to provide a Medicaid reward for those States which enact qualified programs similar to the reward in present law for States which had hospital cost containment programs in place on July 1, 1981. A modest Medicaid reward would be most appropriate for those States which are moving ahead to help solve a national problem-health cost inflation.

We also recognize, however, that any over-all solution to the problem of rising health costs requires a reconciliation of the vital interests of a number of important segments of our society. Therefore we continue to support the appointment of a Presidential Commission, upon which all of these interests, providers, insurers, employers, and unions, among others, can be represented and which can be charged with the constructive resolution of the conflicts which make this problem so intractable.

In closing, I would like to emphasize the importance of cost containment and wellness activities as these have the potential for lowering Medicare expenditures without affecting citizens adversely. The needs of the elderly and their continued access to quality health care are special concerns. Finally, HIAA member companies have a wealth of experience and expertise regarding health insurance programs and we will be happy to serve members of Congress in their study and deliberations regarding the financial problems facing the Medicare program.

Senator BENTSEN. Thank you very much, Mr. Shapland.

I would like to pose these questions to all of you. First, of course, medigap insurance has been a lifesaver to a lot of the elderly, yet many do not have those policies, as several of you noted. Let me get to this point that you touched on, Mr. Shapland.

Is there merit to revising medicare premiums to reflect the income of the payor? Who wants to try that for size?

Mr. SHAPLAND. I guess I might make some comment on that. Facing the reality of the financial problems of the medicare program, we have before us a program where the costs are going to greatly exceed the revenues under the current financing system. We have to look to some source of additional revenues. And I think that is a legitimate one to look at.

I think that the free-enterprise system and the philosophy of the United States is that people should have some responsibility for themselves, to take care of themselves to some extent, to the extent that they can, and if people are wealthy, why should they not take care of their needs more than the ones that are not? I think it deserves study.

Senator BENTSEN. Does anybody else have a different point of view?

Mr. HUTTON. Well, I am trying to restrain myself. As I said in my prepared statement, there are literally millions of older people who probably should not be paying any medicare premiums at all. There are others who are perhaps in the millionaire category who are not paying what perhaps their true share of that medicare to them is. However, as they went through their working years paying, they paid for the past 16 years that we have had medicare, and they paid for a system and I think that they feel very much like fire insurance—you pay and if there is a fire, then the insurance that you paid over the years will take care of it. They feel that perhaps if they have been paying for medicare over all of the years, then the small fees that they have to pay now are fair and legitimate.

But over the past 3 years, extraordinary increases in deductibles and costs have gone on so that if you are asking older people to pay more, then I am afraid that what we are going to do is create barriers to health care.

Senator BENTSEN. That is a different question. I want to keep you on the question because I do not have a lot of time here. I am asking you if the premium payment should reflect something of the income of the payor.

Mr. HUTTON. Well, if it means imposing a means test, I think it would cost more than it would benefit, and I do not think it is the right thing in any case.

Senator BENTSEN. All right. Mr. Merrill.

Mr. MERRILL. I have three comments on that. First of all, from just an equity point of view, if you did graduate the premium to reflect income, why could you not make the same argument for any insurance? Why should somebody who is wealthy pay the same premium for their fire insurance as somebody who is poor?

Senator BENTSEN. I think that is different. I think we are talking about the social objective here and the other is a much more material economic situation on fire insurance.

Mr. MERRILL. Maybe fire insurance is a bad one. But why not health insurance? Why not link health insurance for the under 65 to income as well? It would be the same kind of argument. You are redistributing and creating equity. I do not want to dwell on that. I just raise that as a question.

Senator BENTSEN. Well, the fire insurance premium has to do with the value of the property too, so it is a somewhat different ball game.

Mr. MERRILL. OK. I will withdraw fire insurance.

On the second point, it is not as easy to do because of the fact that you cannot ask each elderly person each year to submit some kind of form indicating what their income is? And the only way you can do it is through the tax system and, frankly, through the tax system—this is my third point—I am not sure what difference it would make.

First of all, half the elderly do not even file income tax returns. So you are dealing with the other half. Second, for the other half, unless you made it a very high amount and then converted it into a premium, you could not raise a lot of money through that mechanism.

Just as an example, if you put through a 1-percent surcharge, we will say—if you did it through that mechanism with the tax system to cover the added premium, you would raise about $1 billion, which would convert to less than $3 per beneficiary per month. So it would not significantly change the premium situation.

So what you would be doing is creating somewhat of a social upheaval in a sense to derive—in terms of the problems of the medicare program—a very small sum of a money.

Senator BENTSEN. OK.

Mr. HACKING. Mr. Chairman, I hesitate to comment on the proposition that you have put forth without knowing the context or the purpose behind it. Would it be, for example, to raise more money to bail out the medicare problem? I would say that making the part B payment amount related to income would be, from the AARP's point of view, a major shift in the program. You would be making what is now a premium into something much more in the nature of a tax. Like Mr. Hutton from the national council, we at AARP are very much aware of what happened last year in social security in terms of the back door means testing of benefits via the income Tax Code. We are also much aware of the proposals that are being discussed, if not so much in public, at least in private, about the means testing of medicare in one way or another, including indirectly through the Tax Code. Therefore, we would be very, very reluctant to come up with a positive response to the proposition you have put forth.

Senator BENTSEN. That is fair enough. Should the catastrophic coverage under medicare include both parts A and B?

Mr. HACKING. We would say yes, and more.

Mr. HUTTON. Absolutely.

Senator BENTSEN. I guess everybody agrees on that.

[The witnesses nod in agreement.]

Senator BENTSEN. Should catastrophic coverage be provided as an optional insurance aspect of medicare or should it be an inte-

gral component of it? Mr. Shapland, I suppose you think it should be an option.

Mr. SHAPLAND. Well, that is what we have right now. We have an optional program and people are choosing to buy it if they want to.

Senator BENTSEN. And the other gentlemen?

Mr. HUTTON. In the main, because they cannot afford it. That is why they do not sell too many of them, because the costs are high.

Mr. MERRILL. Are you referring to if medicare would provide its own optional catastrophic insurance?

Mr. HUTTON. That is something else.

Senator BENTSEN. Yes.

Mr. MERRILL. My sense on that is that with regard to part B coverage, I think you would have to make it optional. I think unless you could somehow relate it to income, which did not seem to have much popular appeal among this group, you would have to make it optional because it is somewhere around $15 a month and that would be a sizable amount. It would not be penalizing anybody more than the current system is because it is optional, but you would not be penalizing them in the sense of forcing them to pay for something they cannot afford.

Mr. HACKING. I would say that, depending on what is covered, the cost of this additional feature if it were something that was mandatory for everybody, could be a very serious financial burden on persons of low or moderate income over time. I suspect we would favor making it optional. I think that the effects would be better over time. But again, we would have to know what is being covered and what is being counted, so we could make some kind of judgment as to what is going to happen to the costs associated with it, whether it is mandatory or optional.

I would just like to indicate that in my testimony, Mr. Chairman, I talked about the HFCA proposal where we are talking about a surcharge on each medicaid enrollee. The HCFA proposal entails a cap at a certain limit and against that cap would be counted the deductible and coinsurance amounts required under the program. HCFA indicated that in 1980 a limit of only $270, a very low trigger figure for the catastrophic protection, would have resulted in a surcharge of about $70. In 1984, however, with a much higher limit of $400, nearly double the $270 figure, a surcharge of $161 would be required from each enrollee. So over the period 1980 to 1984, while we are talking about a much higher limit and, therefore, much less protection, the cost associated with that protection more than doubled. That is a good manifestation of what is happening in terms of health-care-cost escalation.

Senator BENTSEN. You are faced with problems when you talk about increasing medicare to take care of catastrophic coverage and longer hospital stays. Which one of these unpleasant choices would you choose: would you increase the premiums or would you increase the copayments?

Mr. HUTTON. Well, I would not do either. I do not like the way this discussion is going. Actually, health-care costs, Senator Bentsen, have little to do with users' incomes. We need to control the rising cost of hospital costs and doctors fees not just to require certain people to pay more. That is not the thing that we need to do

really. What we really need is to get a handle on the cost situation, control the cost, and then we can start thinking about these things.

I think no one should assume that we cannot get the costs down. To take no action in reducing costs while asking people to pay more for another layer of insurance is not the way to go.

Senator BENTSEN. Well, we are talking about offering more benefits and I think we are all in accord that something has to be done to control the increasing cost of hospital care, all of us agree with that. The question is, how successful we will be in accomplishing that. But I cannot imagine that we will be able to cut it so much that we will take care of the additional coverage, and that is why I think we are faced with this difficult choice.

Mr. HUTTON. And many people are not going to have that catastrophic coverage. They will not have the money to pay for it.

Senator BENTSEN. Is there another comment on that as far as the choices?

Mr. MERRILL. Well, I somewhat disagree with Mr. Hutton. I agree that there is a need to contain health costs. However, I do not feel that is going to happen this year. It is not going to happen next year either. Even the best of intended plans is going to take time for us to see any benefit from and we are confronted with the problem now.

The second thing is that adding a premium or some method of providing some catastrophic coverage under medicare right now is not necessarily something that is going to cost money. For those who have medigap coverage right now, I assure you they are paying more than they would under medicare. So there is a savings, not a cost, associated with it. For those who do not have the coverage, they do not have it now and if it were voluntary they would not necessarily have to have it then, although it may be cheap enough to make it an affordable for some portion of that population.

So we are not arguing choices between something that costs more. We are all agreeing that the longrun solution may come in some overall system of containing costs. In the short run, let us think of something that at least addresses some partial needs that are not fully being met now and may not have greater cost.

Senator BENTSEN. You are looking at the premium more than the copayments.

Mr. MERRILL. That is right.

Mr. SHAPLAND. I was just going to state that if you were only given the choice, because of financial problems, of shifting costs or benefits around in the medicare program and you are asking whether a lot of people should pay more on the front end so they would not have catastrophic costs on the back end, I think that is a legitimate question.

Senator BENTSEN. Gentlemen, I am most appreciative of your being here and the time you have contributed today. I think it is been helpful. It has been a candid discussion with some differences of opinion and we will have to look at some options. Thank you so much.

The subcommittee is adjourned.

[Whereupon, at 11:55 a.m., the subcommittee adjourned, subject to the call of the Chair.]

[The following statement was subsequently supplied for the record:]

STATEMENT

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

MEDICARE CATASTROPHIC COVERAGE

SUBMITTED TO THE

JOINT ECONOMIC COMMITTEE

APRIL 9, 1984

The Blue Cross and Blue Shield Association, representing 96 Blue Cross and Blue Shield Plans, is pleased to present for the record comments on the need for catastrophic coverage under Medicare. The Blue Cross and Blue Shield Association and its member Plans have been major participants in Medicare since its beginning and we are deeply committed to helping work through the problems facing the Medicare program today. Blue Cross and Blue Shield Plans also underwrite benefits to supplement Medicare coverage for between 40 and 50 percent of the Medicare population.

The Medicare program, overall, has served beneficiaries well in providing a basic level of protection against the cost of hospital and physician services. However, the present cost-sharing and benefit limitations under Part A of Medicare do expose beneficiaries to major out-of-pocket costs for inpatient services. Part A of Medicare provides coverage for 90 days of inpatient care per "spell of illness." Beneficiaries are responsible for a first-day deductible equal to the average cost of a hospital day — $356 in 1984. For days 2 through 60, beneficiaries have no cost-sharing, but for days 61 through 90, they are subject to out-of-pocket payments equal to one-fourth of the deductible — $89 per day in 1984.

Part A also provides a lifetime reserve of 60 additional hospital days with the beneficiary responsible for daily coinsurance of one-half of the deductible. Beneficiaries are entitled to 20 days of skilled nursing home care following hospitalization and for an additional 80 days with daily coinsurance equal to one-eighth of the hospital deductible. Beneficiaries are also covered for unlimited home health care without charge, and certain beneficiaries may elect to receive hospice care, generally without additional charges.

Very few beneficairies actually exhaust their inpatient benefits. Recent Health Care Financing Administration (HCFA) data indicate that, since the beginning of the Medicare program, less than 2 percent of beneficiaries who used services actually used any lifetime reserve days. Furthermore, only about 120,000 beneficiaries have ever used all 60 of their lifetime reserve days. However, even without fully exhausting the inpatient benefit, beneficiaries can incur catastrophic levels of out-of-pocket costs because of the sizable deductible and the present cost-sharing. A beneficiary who uses the full 90 days benefits will be responsible for cost-sharing totalling about $3,000. A beneficiary using the 90 day benefits plus the 60 day lifetime reserve days will incur out-of-pocket costs totalling $13,706. This does not include out-of-pocket payments for the Part B deductible, the 20 percent coinsurance under Part B, and any amounts in excess of Medicare allowed charges for physicians who do not take assignment.

Proposals for catastrophic protection under Medicare have quite appropriately focused primarily on increasing the protection against hospital inpatient costs. However, while not as dramatic, the Part B cost-sharing requirements also can be catastrophic for many beneficiaries. Under Part B, Medicare pays 80 percent of the reasonable charges for physicians' and other health services, after the beneficiary satisfies a $75 annual deductible.

Most Medicare beneficiaries, however, are protected against excessive out-of-pocket costs by private coverage which supplements Medicare benefits — Medigap. Overall, 66 percent of the elderly supplement Medicare with private coverage.

We believe the private Medigap market has functioned fairly well to protect the majority of the Medicare population from excessive financial liability. An amendment to the Social Security Act in 1980, often referred to as the Baucus Amendment, established minimum standards for voluntary certification of Medigap policies. Forty-six states have enacted statutes adopting the Baucus Amendment and, thereby, require that certified Medigap programs cover all existing Medicare hospital coinsurance. Approved programs also must cover at least 90 percent of the daily cost-sharing amounts of at least 365 days of acute hospitalization after Medicare benefits have been exhausted. Blue Cross and Blue Shield Plans exceed these requirements in most states.

The premium for Medigap coverage varies greatly across the country both with local costs and with the various benefits that the program might include. Premiums range from $8 to more than $100 per month. On average, Blue Cross and Blue Shield Medigap subscribers pay between about $25-$35 per month or $300-$450 per year.

While we believe that the Medigap programs offered by the private market represent a "good buy" for most beneficiaries, there are those who cannot afford even a minimum benefit package. Our Association served in an advisory capacity to HCFA and SRI, Inc. on a study designed to look at various aspects of Medigap insurance. In the HCFA-SRI study, Medicare beneficiaries who had not purchased Medigap policies were asked why they had not purchased such coverage. Between 45 and 60 percent of the respondents in the six survey states (California, Florida, Mississippi, New Jersey, Washington, and Wisconsin) stated they simply could not afford supplemental coverage.

Clearly, there are those who are exposed to major financial loss because they cannot afford private Medigap protection. We understand and support the desire of the Congress to respond to the need for some protection against catastrophic costs for those who are vulnerable. However, we would urge that the Congress not lose sight of the fact that the private market is providing a catastrophic protection for about 66 percent of all beneficiaries.

In a sense, the private market has "narrowed" the pool of beneficiaries who need additional assistance. We believe that there are a number of advantages in the government's relying on what the private sector can do and focusing on those who cannot afford access to mainstream solutions.

We recognize that addressing the needs of even this segment of the beneficiary poppulation presents the Congress with a dilemma. On the one hand, today's economic environment requires that any new coverage will probably have to be financed by some type of increased beneficiary financial liability — either increased coinsurance or premiums. On the other hand, these beneficiaries probably would not be able to afford the increased burden that greater coinsurance or premiums would impose.

One way of addressing this problem might be to provide catastrophic benefits to all beneficiaries, finance these benefits through increased beneficiary financial liability, and waive the new liability for those beneficiaries who cannot afford it. We believe, however, that this approach would be ill advised for two reasons.

First, we question whether beneficiaries should be required to finance expanded catastrophic coverage when it soon may be necessary for them to accept benefit cuts or additional premiums, or both, to help contribute to the financial solvency of the Part A Trust Fund. Second, we question how most beneficiaries would view the trade-offs between expanding catastrophic coverage or improving other benefits. For example, while the lack of catastrophic coverage has very serious consequences for a relatively small number of beneficiaries, a much larger number would be helped by improving long-term care benefits.

Another approach that has been suggested is to offer catastrophic protection through a voluntary program administered by Medicare. Assuming "budget neutrality," we believe that this approach has the same problem as the current system of private supplemental coverage — what to do about those who cannot afford the cost of additional protection. Also inherent in a voluntary program is the problem of "adverse selection" — those who anticipate the need for coverage will purchase it, while the healthier beneficiaries may postpone buying into the program. This will tend to drive up the cost of the voluntary program and make it even more unaffordable for those with modest incomes.

If the Congress is willing to finance improved catastrophic protection for the low-income beneficiaries through means other than increases in beneficiary liability, a number of options exist. For example, changes in the tax treatment of health insurance premiums for those over age 65 with low income could be explored. We believe that there may be a number of other creative solutions which could be explored, and we would be pleased to work with you in considering the possibilities.

Summary

In summary, we believe that the private market has functioned well in providing protection against major financial loss for the majority of Medicare beneficiaries. We recognize that there are many beneficiaries, however, who cannot afford private protection. We believe that — if the Congress decides catastrophic protection is a priority — any new program should focus on that segment of the beneficiary population.

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